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SEMI-MONTHLY.

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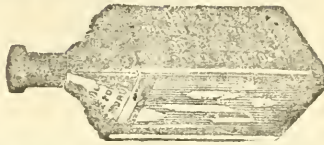
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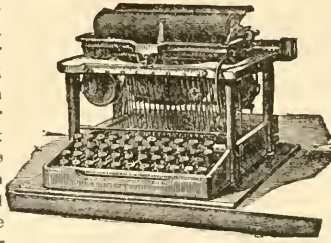
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By R. OGDEN DOREMUS, M. D. LL.D.

PROFESSOR OF CHEMISTRY AND TOXICOLOGY, BELLEVUE HOSPITAL MEDICAL COLLEGE;
PROFESSOR OF CHEMISTRY AND PHYSICS, COLLEGE OF THE CITY OF NEW YORK.

New York, April 17th, 1879.

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By PROF. JOHN ATTFIELD, F.C.S.

PROFESSOR OF PRACTICAL CHEMISTRY TO THE PHARMACEUTICAL SOCIETY OF GREAT BRITAIN;
AUTHOR OF A MANUAL OF GENERAL MEDICAL AND PHARMACEUTICAL CHEMISTRY.

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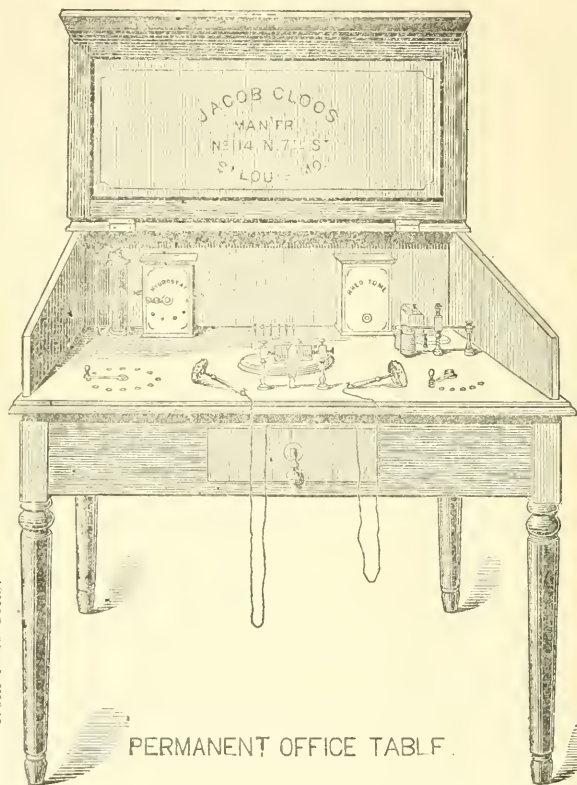
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"The Trommer Company has hitherto taken the lead in the introduction of the Extract of Malt. The uniformity and reliable character of this Extract has induced an enormous demand and sale, so

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ARTICLE XV.

HYPODERMIC INJECTIONS OF ATROPIE SULPHAS ; A SPECIFIC FOR SCIATICA. By G. C. SMYTHE, A. M., M. D., Prof. of Practice of Medicine, Central College of Physicians and Surgeons, Indianapolis, Indiana.

CASE I—M. Shultz, a German, aged 31 years, was admitted to the Putnam County Infirmary, October 15, 1860, with the following history :—While at work repairing a mill-dam about eighteen months previous to his admittance, was attacked violently with what he supposes was rheumatism. The pain being located at first in the small of his back, soon extended down the right hip, and from which he has never been entirely free since the beginning of the attack. But recently the pain has remitted about 3 A. M., followed by an exacerbation about 4 P. M. He has received active treatment, including quinine, iron, arsenic, strychnia and mercury pushed to salivation ; leeching, cupping, blistering and the actual cautery has been used locally. The effects of the latter were still unhealed upon his admission to the infirmary.

He was emaciated and feeble, had a haggard appearance, his countenance indicating intense suffering, long continued. Pulse

feeble, 110 per minute, furred tongue, no appetite, bowels constipated; urine scanty and high-colored; specific gravity 1022. Dull aching pain in sciatic nerve of right side extending into lumbar region and downward nearly to the knee. Very tender upon pressure immediately behind the trochanter major for about two inches along the course of the nerve. This pain becomes sharp and lancinating at 4 P. M. each day, and the patient's suffering is so intense that he has frequently expressed the wish that death might end his misery. The muscles of the thigh are atrophied and contracted, flexing the knee at an angle of about forty degrees, which by no effort of mine can be overcome.

TREATMENT:— $\frac{1}{12}$ of a grain of *sulph. atropia* was injected beneath the skin immediately over the tender spot in the nerve at 3 o'clock P. M., or about one hour before the expected exacerbation.

Patient had all the constitutional symptoms of belladonna poisoning developed in a moderate degree; dilatation of pupils, disturbance of the vision and dryness of the throat, oppression of the chest, iron band around the forehead, delirium and so on. These symptoms subsided in about nine hours and left the patient comfortable and *entirely free from pain, which never returned.*

I saw the patient at noon on the following day and found him, much to my surprise, walking about the ward without pain or inconvenience, the contracted muscles having fully relaxed, and good motion restored to the knee-joint in less than twenty-four hours after the hypodermic injection was administered.

It was my intention to give the patient the $\frac{1}{48}$ of a grain of atropia instead of the $\frac{1}{12}$ which he received. The instrument which I used was one of the first ever made in this country, and was incorrectly graduated, holding twenty instead of ten minims as I supposed, and by a misapprehension on the part of the druggist the strength of the solution which I used was doubled.

No further trouble was experienced by the patient. He is still residing in this neighborhood, and has never had a return of his sciatica.

CASE II—Daniel Conklin, aged 40 years, carpenter by trade, was attacked November 21st, 1867, by acute sciatica in the left nerve, paroxysmal in character, exacerbation taking place at 7 P. M., and lasting about eight hours, pain very acute and lancin-

ating; partial remission takes place in forenoon. Great tenderness upon pressure behind the trochanter major.

On the third day of the attack at 6:30 P. M., used hypodermically immediately over the tender spot $\frac{1}{16}$ of a grain of sulph. atropia. The constitutional symptoms of the remedy were produced as in the preceding case, but all subsided before morning excepting the disturbance of vision, which disappeared in about thirty hours. Relief perfect and permanent without any other treatment.

CASE III—Henry Triplett, of Harmony, Clay County, Indiana, aged 43 years, by occupation a farmer, consulted me on February 20, 1879. Had been suffering with an attack of sciatica for the past five months, and for the last three months had been unable to walk without the aid of crutches; pain almost continuous, but aggravated by cold or damp weather; pain extended downward into the region of the peroneal muscles; flexor muscles of the thigh atrophied and somewhat contracted, so as to flex the knee slightly. After the constitutional disturbance caused by the atropine was explained to him, he declined to have it administered. Returned in six weeks with the symptoms all aggravated and requested me to proceed with the case.

At 10:30 A. M. March 31, 1879, I injected behind the trochanter, the $\frac{1}{4}$ of a grain of atropia, and into the peroneal region the $\frac{1}{32}$ of a grain of the same remedy. Temperature, $98\frac{1}{4}^{\circ}$; pulse, 86; respiration, 18. At 10:50 pupils began to dilate, pulse 86, respiration, 16. 11:30 pupils widely dilated, pulse 96, respirations 21, temperature $98\frac{3}{4}^{\circ}$. At 12:15 pulse 110, slightly irregular; throat very dry, respiration irregular; temperature 99, delirious; 1 P. M. pulse 121, irregular; respiration 30, irregular; temperature $99\frac{1}{4}^{\circ}$; patient alarmed, wants to go home, requires continual watching, which was done by two of my students; patient continued in this condition until 2 P. M., when his pulse was 112, regular; respirations 22, regular; temperature $99\frac{3}{4}^{\circ}$, less delirium, although still has hallucinations and delusions. These symptoms gradually subsided until 7 P. M. The patient was able to sit up and eat some supper, although the accommodation of the eye was still paralyzed; in reaching for articles upon the table, he was apt to miss them. Rested well during the night, left his crutches in my office and walked to the depot without them, nearly a half

mile, and has never used them since, nor had any return of the disease.

Careful and frequent observations were made of the pulse, respiration and temperature in this case, to see what the effect of the remedy would be upon these points, belladonna having been claimed as one of the few remedies which would elevate the temperature of the body. It will be observed that there was an elevation of $1\frac{1}{2}^{\circ}$, and at a time of day when it could not be claimed as the normal elevation which takes place in the evening; besides it receded with the other symptoms. This is an important point to which I wish to call the attention of the profession. The remedies which were supposed until recently to elevate the temperature, such as quinia, alcohol, etc., really have the contrary effect, and we are without any trustworthy remedy which is known to produce an elevation of temperature in the human body.

This treatment has been used by myself and some of my professional friends, altogether in about fifteen cases, with uniform success, so much so that I do not hesitate to say that I believe it to be a specific for the disease. It has succeeded in some cases after the failure of almost every other method, including the hypodermic use of sulph. ether, as recommended by an eminent physician of Cincinnati.

I am influenced in publishing this article by the prominence which the barbarous practice of nerve-stretching for the disease has attained recently. I believe this latter operation in many cases, if not all, will be rendered unnecessary if atropine is properly used.

I propose no speculations or theoretical explanations in regard to the *modus operandi* of atropine in curing sciatica. This is not an age of theories—what we want are facts, although their discovery may be empirical and accidental.

This remedy must be used in full doses. If less than the $\frac{1}{24}$ to $\frac{1}{12}$ of a grain is used, the success will only be partial, and after the patient has suffered from the drug once without relief, it may take some persuasion to induce him to undergo it again. I tried the effect of a small dose, $\frac{1}{40}$ of a grain, in one case. The relief was only partial, and it was several days before the consent of the patient was obtained for a repetition of the remedy. The $\frac{1}{16}$ of a grain produced a permanent cure, since which time I have never used less than that quantity.

The remedy must not be used when the system is under the influence of opium or any of its preparations, owing to the antagonism known to exist between these drugs.

If any dangerous symptoms should appear, they are readily counteracted by any of the preparations of opium. In none of my cases did I deem it necessary to use the antidote.

I tried this remedy in two cases of gonorrheal sciatica without any permanent relief. The medicine was administered three times in one case, and twice in the other, producing its full constitutional effect each time; hence I am forced to the conclusion that this rare form of disease does not yield to the remedy any more readily than gonorrheal rheumatism will yield to salicylic acid.

ARTICLE XVI.

DISEASE OF THE SACRO-ILIAC SYNCHONDROSIS, MISTAKEN FOR RHEUMATISM, PSOAS-ABSCESS AND MORBUS COXARIUS.* By J. T. BINKLEY, M. D., of Shawneetown, Ill.

Miss R., at death eighteen years old. Family history: strumous diathesis, small, delicate, quick, nervous and energetic. June 1873 she leaped from a carriage whilst it was moving rapidly. The shock was violent; indeed, so much so, that from that time may have dated the commencement of her trouble. The concussion about the pelvis at the time caused pain and uneasiness, which never after entirely subsided; at times causing considerable suffering, especially after free exercise upon the feet. Notwithstanding all this pain and uneasiness, her general health and appearance for nearly a year, seemed unimpaired. Yet there were frequent deep-seated, sharp, lancinating pains, in the back, hip and gluteal region of the right side, often extending to the knee and occasionally to the ankle, with slight lameness. The pain in the back was along the sacro-iliac articulation, and

*Read before the Southern Illinois Medical Association, held at Shawneetown, June, 1880.

always increased by exercise on foot. When perfectly quiet, there was almost total immunity from pain.

She was first treated for rheumatism, nearly a year, with general and local remedies, the latter consisting of various embrocations usually employed to relieve pain. The former the usual anti-rheumatic alteratives—all, with no benefit, save slight palliation.

What was the cause and why the importance of these phenomena? The cause of the pain along the sacro-iliac articulation and gluteal region, was disturbance of the sacral plexus of nerves. That of the knee and ankle, disturbance of the obturator, anterior crural, long saphenous and cutaneous branches of the sciatic nerve. Important, because they are the precursors of fatal disease and require prompt attention and proper treatment, or the case will be hopeless.

Under the treatment instituted in the above cases, it grew constantly more serious, until the following June, when it was sent to Covington, Kentucky, and placed in the hands of Dr. J., who made a careful examination and discovered a large fluctuating tumor, extending from the third lumbar vertebra to the lower third of the sacrum to the right of the mesial line. After the examination, his diagnosis was psoas abscess, and that her symptoms had been caused by pressure upon the sacral nerves, to relieve which it would be necessary to open the tumor. This he did about the middle of June, giving much relief. Dr. J. now informed his patient that she need suffer no further uneasiness, as her health would soon be restored. He then gave prescriptions for tonics and stimulants, with directions to keep a tent in the opening to prevent its closure and facilitate the discharge, that the abscess might heal from the bottom.

I am satisfied that Dr. J.—'s great mistake and failure was the result of not enjoining absolute rest, instead of which he suffered his patient to continue on foot and thus hazard the only chance of future recovery; even the day before she started home she walked from Covington to Cincinnati, and then did considerable running around; returned on a steamer, and on her arrival walked home from the boat. After this her lameness increased, and she was for the most of the time confined to her bed. She again employed her former physician, until August 24th, when I was requested to treat the case. On assuming this responsibility, I made a careful investigation of all physical phe-

nomena, together with a detailed account of the history, from its commencement to this time. At this time I found a large ulcer on the back, from one and a half to two inches in diameter, where the first tumor was lanced; the edges were indolent and covered, for some distance from the margin, with a glutinous pus. In addition, another large fluctuating tumor in the right inguinal region, near the anterior inferior spinous process of the ilium, causing but little pain or inconvenience; the skin, presenting a thin, glazed, ivory appearance. The right leg was slightly flexed and adducted, yet no pain in the glenoid cavity, when the limb was freely moved in all directions; the pelvis being supported. The head of the femur was in its normal position, percussion on the heel, with the leg extended, caused no pain nor unpleasantness about the acetabulum.

This examination satisfied me that it was neither psoas abscess nor hip-joint disease, but disease involving the sacro-iliac articulation. The tumor in the right side was now increasing rapidly, and becoming quite prominent. This being the condition of affairs, I decided to open at once; which I did, and discharged a large quantity of strumous matter, thus leaving the integument in the location, corrugated and relaxed. This, instead of healing, like the first, commenced ulcerating, and soon two openings were formed; one occupying the point where it was lanced, the other about a half inch inside of it. Both ulcers were now making fearful havoc upon the soft parts, beneath the skin; they were literally melting away like ice exposed to a genial wind. The integument about both was less vigorous and wasted slower; in fact, the skin, covering the anterior openings, was losing its vitality for two or three inches in diameter, assuming a dry, oily appearance.

About the 12th of Oct., it was evident that my patient was gradually wearing away, the symptoms all becoming more alarming. The extremity strongly flexed and adducted. Incontinence of the urine, with constant dribbling, passing back and irritating the wound, thus increasing the trouble already existing. The bowels torpid; never moving, save when induced by enemata.

I saw my patient daily, cleansed and disinfected the ulcers in the best manner I could, to procure as much rest and comfort as possible.

Oct. 15th.—The two ulcers have connected, the posterior

being the most dependent; the matter from both passed that way.

The end was now near at hand, as shown by the rapid sinking of all the vital functions. She expired on the second of November, 1874, after an illness of about eighteen months.

TREATMENT—One prominent feature in it, was its failure. I, however, at different times used the following therapeutic agents: iodides, bromides, phosphorus, hypophosphites of lime, soda, etc.; cod-liver oil and electricity; together with anodynes narcotics, etc., as symptoms demanded. Local appliances, compression about the inguinal opening, nitrate of silver solid, and in solutions of various strengths. Solutions of carbolic acid of different strengths, bromo-chloralum one to eight, and one to ten. Solution of carbolic acid and fluid extract of *Pinus Canadensis* combined, also Lugol's solution largely diluted; and as dessicators, calomel, oxide of zinc, sub-nitrate of bismuth, etc. In fact, almost the entire list of alteratives, tonics, caustics, astringents and detergents were used, but with little benefit.

There was no post-mortem, but as I was requested to dress the ulcers and straighten the limbs, I noted the following points:

Most of the soft parts in the iliac fossa, and along the ilio-pectineal line to the sacrum were gone, leaving the bone partially exposed. The cartilaginous connection, between the sacrum and ilium was entirely destroyed the whole length of the articulation, together with portions of both bones along the margin of the joint. Considerable portions of these bones were exposed by the ulceration on the back. On forcibly extending the limb, I found no obstruction except the muscular contraction. The head of the femur was in its normal position, and its articulating surface perfectly healthy.

The condition the various parts were found in after death, verified my diagnosis.

ARTICLE XVII.

POLYPUS TUMOR OF THE UTERUS AS A CAUSE OF POST-PARTUM HEMORRHAGE*. By HENRY C. MITCHELL, M. D., of Corinth, Ill.

March 23d, 1880, I was called to see Mrs. H——, a parturient lady. On arriving at the house, I found her in a fainting fit. I asked at once what the trouble was, and was informed by the midwife that she had delivered her of a child, and in attempting to get away the after-birth, had pulled off the cord. I examined the pulse and found it very quick, soft, and easily compressed; the breathing was hurried, and quite labored; all the symptoms, I concluded, were quite indicative of hemorrhage. On passing my hand under the covering, preparatory to making a vaginal examination, I found a large pool of coagulated blood, and hence I concluded at once that my patient was in a syncope from loss of blood, due to retention of a partially detached placenta. I then introduced my finger into the vagina as far as the os uteri, which was dilated sufficiently to admit the index finger. The blood was escaping very rapidly through the dilated os. With one finger in the cervical canal, and by means of bi-manual palpation with the other hand over the abdomen, I was enabled to feel the placenta, which was still retained in the uterine cavity. I then introduced my *hand* into the vagina, and by passing my fingers successively into the uterus, I was soon able to introduce my hand. I found the placenta firmly adhered to the side of the fundus, over nearly its entire surface. I then made traction against the whole mass, but soon found that I could not remove it in this way. I then hooked my fingers over the top of it, and gradually removed it by tearing in two the bands of adhesion. I then gave her ergot and brandy, which should have been given as soon as the condition of things was ascertained, and in a very short time she had recovered from her syncope, and the hemorrhage had entirely ceased. She then progressed very well until March 30th, when I was again called to see her, and found that she had fainted from uterine hemorrhage. Supposing it to

*Read before the Southern Illinois Medical Association, held at Shawneetown, Ill., June, 1880.

be due to inertia of the uterus, I administered ergot, opium and brandy, applied a compress over the fundus uteri, and plugged the vagina with cotton saturated in a solution of tannic acid, which readily controlled the hemorrhage. In the course of twenty-four hours I removed the tannin, without any recurrence of the bleeding. April 3d I saw her again, and she told me she had suffered from the hemorrhage more or less every day, and at times it was quite profuse. Supposing the hemorrhage due to either a portion of retained placenta, or to a clot of blood, I made an examination with the intention of removing it. I found the os only partially dilated, not sufficient to introduce my finger; I then introduced a sponge tent for the purpose of dilating it, and on the following morning found it dilated sufficiently to admit two fingers. Then I found, just at the internal os, a mass of tissue, which I supposed to be placental; I then introduced a Sims' speculum, and fully exposed the cervix; introducing my placental forceps I then grasped the mass, and made traction, but could not remove it. On making torsion I found, from its resistance, that it must have a point of attachment; I then twisted it very hard, and the attachment gave way, and on examining it, I found I had removed a polypus tumor, the size of a small hen's egg. The hemorrhage has never recurred since the removal of the tumor. The query is, was my first treatment of the case conservative, considering the condition of the patient, or should I have plugged the vagina, and allowed the placenta to have been expelled by uterine contractions?

Secondly. Was the polypus in the uterus at the time of labor, or was it developed afterward?

Thirdly. Is this kind of case commonly a cause of post-partum hemorrhage?

ARTICLE XVIII.

ABDOMINAL SURGERY.—CYST OF BROAD LIGAMENT—LAPAROTOMY, RECOVERY.* By F. J. LUTZ, A. M., M. D., of St. Louis.

It is difficult, I dare say impossible, to utilize medical associations for purposes of scientific investigation, but by a proper exchange of experience and views they can be made efficient agents in the dissemination of scientific results; and it is with this object in view that I penned the following remarks upon a subject so full of interest and so very important, which is as yet barely emerging from that first epoch in the history of every great advance in surgery.

The deplorable fatality which formerly attended wounds of the peritoneum was a sufficient reason for the older surgeons to dread this class of injuries more than all others, and we are therefore not surprised to hear from John Bell the terse observation: "Hence it comes to pass that in one short sentence we announce the general principles of such wounds, and in one short and general prognostic we declare them to be fatal." Nor is it difficult to picture to ourselves the despair of Abernethy, to whom is attributed the quaint remark that Nature would have nothing to do with these cases, but stood by and shook her head and left the patient to his hopeless fate.

How very different is the opinion held by surgeons of our day! We are told, and the assertion is strengthened by an array of successful results which seem to defy contradiction, that wounds of the peritoneum are not at all dangerous; that the peritoneum may be subjected to insults of all kinds with impunity; that it may be pierced, cut, torn, bruised and burned without danger—provided only a watchful eye be kept upon infection. (Schroeder.) In our day feats are accomplished in abdominal surgery of which the older surgeons never dreamed in their most fanciful reveries: tumors weighing fifty and sixty pounds are removed from the cavity of the peritoneum and the patients recover without any great rise of temperature or an alarming

* Extracted from the Transactions of the Medical Association, of the State of Missouri.

increase in the frequency of the pulse; and I need only remind you of the many lives which have been saved by enterotomy, which, under the old regime, were consigned to a premature grave, and to the great alleviation of suffering by the timely performance of gastrotomy.

Hence the idea at once suggests itself that the older surgeons were certainly very much mistaken when they considered injuries of the abdomen so exceedingly dangerous, whereas they have proved themselves comparatively harmless. The audacity of this view we shall presently show, and at the very outset we will say, that in spite of our increased knowledge of the causes which effect their great mortality and therefore our increased success in combating them—for an enemy whose strength and position is known is easily conquered—abdominal injuries are and always will be dangerous lesions.

What then are the dangers attending these injuries and how may we avoid or at least combat them?

The first great danger which arises on opening the abdominal cavity consists in the exposure of the peritoneum to a lower temperature. The peritoneum as you know is a very large serous sac, the surfaces of which are continually moist and glide smoothly over each other. A sudden cooling of this immense surface may result in reflex paralytic conditions of the heart and in death.

In the next place, the power of absorption of the peritoneum is so great, that any exudation which may have undergone putrefactive changes, and which will be most rapidly absorbed, will produce rapid and serious septicæmia.

Add to this the peristaltic motion of the bowels by which everything which enters the peritoneal cavity is carried over the entire surface, and the descent of the diaphragm and the small intestines occurring during respiration, and which are augmented by the pressure of the abdominal parietes—and you have additional important factors to increase the power of absorption of the peritoneum.

Again, the numerous convolutions of the intestines and their relation to each other and to the other abdominal viscera, result in numerous lacunæ in which secretions may lodge and be unable to escape, thereby offering the most favorable opportunity for their decomposition and subsequent absorption.

The fact that intestinal gases impart their peculiar odor to

adjacent collections of pus and secretions is so well known, that I need only remind you of the sickening smell of abscesses in the neighborhood of the bowels, the cavity of which does not communicate with the intestines, to bring this danger of septicæmia home to your minds. And in cases of severe injury to the intestines in which the process of exosmosis has been paralyzed, so to speak, not only the gases, but also the fluid contents of the bowels find their way through the intestinal walls.

These then are the dangers—the knowledge of their nature suggests their remedies, and it is to knowledge that modern surgery owes its triumphs in abdominal surgery.

To meet the first danger we perform our operations in an atmosphere of about 80°; we wrap our patients warmly, and have everything that is to come in contact with them, before and after the operation, of a proper temperature. The shock to the peritoneum, and through it to the system at large, is thereby greatly diminished. The efficacy of the noxious ingredients of the atmosphere which are said to cause the putrefactive changes in wounds we attempt to destroy by saturating the atmosphere of the room with antiseptics, whereas the operation itself should be performed under what are termed antiseptic precautions. The power of absorption, which the peritoneum possesses to so great a degree, can, of course, not be destroyed, but we can remove, with scrupulous care, everything which could possibly be the source of irritation, or which could possibly be absorbed, and therefore too much time cannot be spent upon the toilet of the peritoneum.

On the other hand the peristaltic action of the peritoneal organs should be diminished by large doses of opium before the performance of an operation, and afterwards it is our sheet-anchor.

The firm, large bandage which is used after operations about the abdomen assists in no small measure in diminishing abdominal and diaphragmatic respiration, whereas the insertion of tubes in proper localities prevents the lodging of secretions in the numerous lacunæ for a sufficient length of time to undergo putrefactive changes. Even the intestinal gases can be counteracted to a certain extent by a proper dietetic preparation of our patient for the operation, and by the administration of large and frequent doses of potass. chlorat.

I have thus briefly, and, as I am aware, most imperfectly,

sketched the dangers of abdominal wounds and their antidotes, not because I do not deem them of great importance, but because I wished only to suggest the discussion of this important subject; and in conclusion, I will report, with your permission, a case of laparotomy for the removal of a cyst of the left broad ligament.

Cystic tumors of the broad ligament so closely resemble unilocular ovarian cysts as to be diagnosticable only by a chemical and microscopical examination of their contents, obtained by aspiration and they rarely attain so large a size as this one. They form between the layers of peritoneum which envelope the broad ligaments, and are supposed to arise from an increased secretion from the walls of the numerous tubes which compose the parovarium.

Tillie H., the young lady from whom the tumor was removed, consulted me for the first time on the 12th of January, 1880. She is seventeen years old, single, but remarkably well developed for her age, and presents the appearance of a woman in the ninth month of pregnancy. At the age of thirteen she began to menstruate and has always had a regular, although somewhat copious menstrual flow. She has always enjoyed good health except during the last year of her attendance at school, when she suffered from chlorosis. About two years ago she noticed a hardening and gradual swelling of her abdomen which has since continued to enlarge, but annoys her only by its size. She is not perceptibly emaciated nor is her general health implicated. Axillary temperature 99°, no glander enlargements, no varicose veins and no œdema of the lower extremities, nor have any perceptible changes been wrought in the mammæ or the areolæ. Mensuration from the umbilicus to the right and left ant. sup. spinous processes of the ilia respectively, shows one inch and a half in favor of the left side. On palpation a movable, regular but somewhat dense tumor is discovered over which the abdominal walls roll freely; the abdominal parietes are not œdematous nor are the abdominal veins enlarged. Fluctuation of the tumor is very distinct and superficial. Percussion elicits a dull sound, upwards to the epigastrie region on the right side to about middle of lumbar region and inguinal, below to the symphysis and over the whole left side. The uterus is of normal depth and freely movable. Occasionally she suffers from a frequent desire to micturate, but this annoys her only for a few

hours. A chemical and microscopic examination of the urine furnishes only negative results. Her tongue is clean, appetite good and bowels regular. She sleeps well. Her respiration is frequent but not embarrassed; the respiratory murmur and heart sounds are normal; pulse 120 per minute; aspiration was not permitted; unilocular cyst—probably of left ovary—was diagnosed.

As the patient was comfortable and her general health not involved, she was advised to wait. From time to time she was seen, but no marked change occurred until the latter part of February, when she experienced some difficulty in ascending stairs, and her health began to fail as evinced by a loss of appetite and emaciation. At her urgent request, and I may here say in parenthesis, that a more heroic and confiding patient cannot be imagined, he was prepared for the operation which I performed on the 9th of March, assisted by Drs. Gregory, Wesseler, Bernays, Atwood, Hickman, DeCailhol, and Fuhrmann. List-erism with all its numerous details was carefully observed. Dr. Atwood kindly took charge of the anæsthetic. At first ether was administered, but it was found that the time required to produce anæsthesia was too much prolonged, and chloroform was substituted. The chloroform narcosis was, however, attended with that much dreaded symptom—vomiting, and during the operation it became necessary a number of times to cease all further proceedings until the vomiting was controlled, which was always successfully done by pushing the chloroform. After the patient had been placed on the table a pint of clear straw colored urine was drawn off and an incision was made in the linea alba, under the spray, about four inches in length. Before the peritoneum was reached two veins were ligatured and one small artery was torsioned. When all hemorrhage had ceased the peritoneal cavity was opened and the large cyst, which had all the appearances of the bladder, at once completely closed the abdominal incision. Adhesions were sought for with a sound and as none were discovered the cyst was transfixed by Dr. Borek's ingenious cyst elevator, which was entrusted to Dr. Hickman, whilst Dr. Bernays gently yet firmly pressed the abdominal parietes against the tumor. The trocar was then introduced between the prongs of the elevator and as the contents of the cyst, a clear straw colored, albuminous liquid to the amount of thirty pints escaped, the cyst was gradually drawn

from the abdominal cavity by Dr. Hickman. When the long broad pedicle came outside of the parietes, it was found that the cyst grew from the broad ligament. The pedicle was secured by a clamp, two carbolized silk ligatures were made to transfix it under the clamp, and then the cyst was removed with the knife above the clamp. During the whole procedure neither the hand nor an instrument, except the sound, nor a sponge were in the abdominal cavity, nor were the intestines or ovaries seen. The pedicle, which was very long was sewed into the middle of the abdominal wound. The wound, after being united with deep and superficial silk sutures, was dressed antiseptically. Slight vomiting occurred during the afternoon, but the patient slept well during the first night, and next morning I found her with a temperature of 99° , pulse 108, and not complaining of pain. Drew off half a pint of urine.

I consider it unnecessary to detail to you the various ranges of the temperature and pulse; suffice it to say that the highest temperature $100\frac{1}{2}^{\circ}$, occurred on the evening of the third day after the operation. On this day there was a slight show of the catamenia. On the fifth day an injection of lukewarm water was followed by a copious evacuation. The dressings were removed for the first time on the fifth day, under the spray, and the wound above and below the insertion of the pedicle was found united by first intention. The superficial and two deep sutures were removed. Four days afterward the wound was again dressed and all the sutures were removed. A small abscess had formed in the left abdominal wall; it contained about a drachm of laudable pus. One of the ligatures of the pedicles was by mishap cut off near the knot, and will no doubt become encysted. The wound is entirely closed. The patient is entirely well. Six weeks after the operation she menstruated.

P. S.—Contrary to my expectations, the ligature which remained in the abdomen did not become encysted, but the wound opened and suppurated for a few days, after which the patient extracted the projecting ligature with her fingers. The wound is again healed. The patient is growing perceptibly stronger.

JULY 15, 1880.

ARTICLE XIX.

THE SYMPTOMATOLOGY OF OPTIC NEURITIS.* By E. WILLIAMS,
M. D., of Cincinnati, O.

The growing interest in diseases of the brain and nervous system, has received a new impulse by the discovery of the Ophthalmoscope. The optic nerve as it enters the bottom of the eye and expands to form an important part of the retinal cup, is now open to direct inspection and study. Its physiological appearances, and the changes wrought by disease, can be seen and followed by the aid of that beautiful and simple contrivance, as though they were brought to the surface. All the nerves of special sense are but sentinels sent out through the turret holes from the masked battery, the brain.

Of these, the optic cord is the largest and the only one that can be directly seen. The very structures through which it is seen are but a microscope focused upon the optic disc and inviting the curious observer to look in and see what is going on in the laboratory of thought and feeling and life. A part of the brain thrust out into plain view and supplied by a system of vessels coming directly from and returning to that organ, it is a sort of Eldorado in the medical student's world of study. As he gazes upon it and sees the pulsating artery and the swelling vein as an integral part of the cerebral circulation; watches the physical changes as they are brought out one by one, in its delicate and transparent structures, by disease, he feels that the secrets of pathological anatomy are beginning to dawn upon his own inquisitive brain. It is well known that the condition of the optic disc and surrounding retina is often an index not only to certain alterations within the cavity of the cranium, but to the seat and character of other remote and scarcely less important diseases, as well as to certain changes in the normal constitution of the blood, and to constitutional poisoning.

Of the intra-cranial affections, which often reveal their secrets

* Read before the Tri-State Medical Society, held at Evansville, Ind., November, 1879.

through morbid changes seen in the optic disc, may be mentioned cerebral tumors and meningitis.

The optic disc in many of these cases becomes swollen, projecting more or less prominently into the vitreous humor; hazy in appearance, obscuring the plain boundaries between it and the retina; the veins enlarged and tortuous, and the arteries diminished in size, if altered at all. Diverging white lines are often seen on the face of the disc and the adjacent zone of retina, arising from alterations in the radiating nerve fibres—also minute broken hives of ecchymoses following the same arrangement, but appearing along the courses of the retinal vessels generally, both on the disc and beyond it, and most marked often at the sudden short bends in the veins. The disc rising more or less perpendicularly forward raises the veins with it, making abrupt flexures, after which they dip down toward the natural level of the retina, and continue in a very serpentine way towards the equator. If the swelling and infiltration of the papilla are great, the arteries are entirely hid till they reach the retina and the veins appear as veiled dark lines, appearing and disappearing at short distances or even entirely hidden on the face of the disc and beyond it. As followed into the retina they are always very tortuous. The boundaries of the disc being no longer visible and perhaps all the vessels on its surface, it is then only possible to locate the papilla by the concentric vessels seen around it. This state of the optic papilla, of a dirty stippled red color or bluish-gray, according to the kind and extent of the infiltration, is called “choked disc”; “*Stauungs-Papilla*” by von Graefe, and by common usage, optic neuritis, determined, as supposed, by venous stasis in the retina, caused by increased intra-cranial pressure, telling upon the cavernous sinus. This was the theory of its mechanism, held by von Graefe and others at first. The free anastomoses between the ophthalmic and the facial veins afterwards demonstrated, allowing the over-full retinal veins to empty themselves by the collateral circulation, led to doubt as to the accuracy of this explanation. Then cases were published where the cavernous sinus was completely obliterated, without any optic neuritis or retinal congestion during life. Von Graefe then described two varieties of neuritis—the one beginning in the eye and ascending along the cord towards the brain—neuritis ascendens;—the other following the optic tracks and nerves from the brain

to the eye—neuritis descendens. While this distinction holds in rare cases, the differential diagnosis is by no means easy or often possible.

In the immense majority of cases of optic neuritis, the changes begin in the visible optic papilla and remain within the lamina cribrosa of the sclerotic, the nerve showing little or no change beyond the eye. The discovery of Schwalbe, that the arachnoid cavity of the brain communicates with the membranous sheath of the optic nerve through the foramen opticum, gave rise to a new and more generally accredited mechanical theory of the formation of the choked disc. The increased intra-cranial pressure forces the arachnoid fluid into the sheath of the nerve causing distension, pressure on the nerve, and arrest of the free return of the blood from the retina to the cranial cavity. The sheath, in some cases, being found much dilated after death, especially near the sclerotic, helped to confirm that view, and this theory, more or less modified, has been held by most writers since. There are, however, very grave objections to it, but which my limits will not allow me to discuss. Other explanations have been offered and defended with much zeal. The last, and that which seems to me to accord with the largest number of clinical observations and post-mortem findings, has been lately published in the *Annales d'Oculistique*, for July and August, 1879, by Dr. H. Parinaud. He says: "In the autopsies I have made of optic neuritis, I have been struck with the coexistence of these three facts: alteration of the optic nerve, hydrocephalus, and cerebral oedema."

He claims that the choked disc is essentially an oedema of the intra-ocular end of the optic nerve, of the same character as the oedema of the brain, and that the three combined symptoms are explained by an impediment in the lymphatic circulation of the brain and optic nerve. In the delicate lymphatic network and vessels that envelope all the blood vessels of the brain and nerve, to their finest ramifications, circulates a serous fluid with lymph cells and certain other elements of the blood. These lymphatic spaces and vessels communicate freely with the meshes of the pia mater and all contain the cerebro-spinal fluid. The small spaces in the pia mater are also in communication with the sub-arachnoid spaces situated in the fissures of the convolutions, at the base of the brain and around the medulla oblongata, and the subarachnoid spaces connect with the cerebral ventricles. He

says: "It seems demonstrated that the cerebro-spinal fluid springs, by simple transudation, from the capillary arterioles in the depths of the nervous substance, and extends into all the lymph spaces described, so that these spaces and particularly the ventricles, form a vast reservoir into which the fluid exhales or flows." Now if from any cause this fluid increases, augmenting the tension of the cavities which contain it and in which it circulates, it produces an obstacle to the lymphatic circulation. The elements of the lymph are then retained and produce œdema of the brain, by a similar mechanism to that which produces passive œdema from obstruction to the venous circulation. The optic nerve, which is a veritable prolongation of the encephalon into the orbit, has its sheaths enclosing lymph spaces, and its fine vessels surrounded by a fine network of lymphatic vessels in which an active circulation is going on. Schwalbe and others have proved that the lymphatic vessels of the optic nerve empty their contents into the subarachnoid spaces and ventricles. The brain and optic nerve thus have a common lymphatic circulation and both suffer in the same way, when it is impeded. The order of the phenomena is first hydrocephalus and then œdema of the brain and the optic nerve. So called optic neuritis may then occur in any intracranial derangement that produces hydrocephalus. It appears oftenest in acute meningitis and tumors because these most frequently give rise to dropsy of the ventricles. If it occurs oftener in affections at the base of the brain, than in the convexities; it is because these regions are nearer the ventricles where they excite more readily hypersecretion of the cerebro-spinal fluid. It is conceded that in nearly all cases of neuritis, microscopic changes indicating positive inflammation, are not developed till a very late period in their course, and often not at all, even after years.

Dr. Parinaud has examined several cases of optic neuritis in tubercular meningitis. In all he found the same changes, consisting in an accumulation of lymph corpuscles in the nerve, especially at its peripheric end. They were found mostly in the interfascicular and perivascular spaces in the connective tissue, where the circulation of the lymph in the nerve takes place. They are found mainly in the intra-ocular portion of the nerve and adjacent parts of the retina and choroid, as well as in the subvaginal space of the optic nerve. "This infiltration is not accompanied by any fibrinous exudation; any proliferation of

connective tissue, or alteration of the nerve fibres; it is the result of œdema."

Tension of the brain ventricles reacts on all the diverticula of the intracranial lymph spaces, resulting in stasis in the subvagal space and nerve itself. It is well known that many very serious and fatal affections of the brain, even tumors, run their entire course without any appearance of optic neuritis, and in these it is alleged that no œdema of the brain, distension of the ventricles with increased intracranial pressure occur, these being the three necessary links in the pathological causation of neuritis. The occurrence of changes in some cases, but nearly always at a late period, of alterations indicative of genuine inflammation, accords with the well observed facts of inflammation arising from passive congestion; either venous or lymphatic, in other organs and parts. Parinaud would call this disease "œdematous neuritis." His conclusions are as follows: "The different intra-cranial affections only produce œdematous optic neuritis (stanungs-papilla) when complicated with hydrocephalus. In acute meningitis, particularly, we find no relation of the intensity of inflammation, the seat of the exudation, and the encephalic lesions, to the alterations of the disc, which, on the contrary, constantly exists with effusions into the ventricles."

In cerebral tumors, the seat and volume of the growth have only a secondary importance. Optic neuritis may be absent with very large tumors, and present with very small neoplasms, provided they are associated with hydrocephalus. To produce optic neuritis, the hydrocephalus must be reasonably abundant, and also find in the walls of the cranium sufficient resistance to modify the intra-cranial tension.

The different theories by which it has been attempted to explain the influence of intracranial pressure on the papilla, are not satisfactory. Those referring the alterations of the nerve to venous stasis are contrary to clinical observations, and to the results of experiments. There is no immediate relation between the intracranial pressure, and the circulation in the fundus of the eye.

The theory of neuritis by migration, in which it is supposed that the cerebro-spinal fluid, or inflammatory exudations are pushed from the cavity of the cranium to the lamina cribrosa of the sclerotic and papilla, along the subvagal space of the nerve or the nerve itself, although more in accord with observation, is

still open to objections. The importance attributed to the fluid found in the sheath of the optic nerve has been exaggerated. Optic neuritis would take place all the same if this space did not exist.

Intracranial pressure alone seems to be insufficient to react on the papilla. Hydrocephalus only produces optic neuritis by the cerebral œdema which it gives rise to. The œdema of the nerve is of the same nature as that of the brain. It is the consequence of the lymph stasis caused by the ventricular effusion.

The lymphatic network of the optic nerve is a dependence of that of the brain; it is natural that the nerve should feel the effects of hydrocephalus, the same as the encephalon itself. Histological alterations furnish a powerful argument in favor of this method of explaining neuritis. It is no objection, that inflammatory alterations are developed in the advanced periods. These same alterations are observed in passive œdema of other parts of the body.

The optic neuritis by strangulation (*stanungs-papilla*), which would be more properly named œdematous neuritis, or simple œdema of the optic nerve, can furnish no certain indication of the seat or nature of the intracranial affections which produce it. It has but one signification, the existence of hydrocephalus, and cerebral œdema.

I have dwelt upon this theory more than the others, because it is new, and seems to account more satisfactorily for the clinical and histological features of this interesting disease. Optic neuritis with its marked and characteristic symptoms, is a very valuable aid in the diagnosis of intracranial diseases, and when both discs are affected, almost positive. But even double neuritis, with all the most characteristic symptoms of tumor of the brain, such as severe paroxysmal headache, preceded or attended by sudden, causeless vomiting, generally without previous or subsequent nausea, and a history of slow development, and gradual increase, often with remarkable fluctuations—all these, and more cannot make the diagnosis of tumor sure, but only probable. Much less can any combination of symptoms indicate the exact nature, extent or seat of the morbid process.

I remember a number of cases in my personal experience, where my diagnosis of the existence, and sometimes the supposed seat of the tumor, have been confirmed by the autopsy.

I recall a case of double neuritis, and very extensive retinal

hemorrhages in both eyes, with a history and symptoms which made the diagnosis next to certain. The woman was 48 years old, and I made of course a fatal prognosis. I marked in my book, tumor at the base of the brain, and an early fatal issue.

That was Nov. 16th, 1878, and she died on the 27th, and a tumor was found by Dr. Alexander, of New Albany.

In another patient, a woman of 47 years, with marked double neuritis, and other symptoms that led me to locate the tumor at the anterior part of the base of the brain, and predict an early, fatal termination, the woman is still living, and does not believe I understood the case, because she has not died according to orders. Her physician, my old and valued friend Dr. A. G. Preston, of Greencastle, Indiana, who referred her to me Nov. 5th, 1878, is seriously embarrassed in trying to maintain the confidence of herself and friends, in my diagnosis. The diagnosis of glaucoma had been made by her physician, and iridectomy urged, then and still.

At that time the evidences of serious organic brain disease were unmistakable, and her vision was reduced to quantitative perception of light. Under the treatment prescribed her sight returned to some extent so that she could walk about the room and distinguish faces. But under a paroxysm of headache and vomiting sight totally disappeared for some months. At present she has no useful vision but can discern wagons and buggies passing in front of her door. Dr. Preston writes that she continues to suffer from a sense of weight and fullness and pressure above the eyes.

The following case, diagnosed and treated by Dr. Robert Sattler, my assistant, and in which a post-mortem was made and the specimen found which I will show you directly, will, I trust, prove interesting. It is a type case of cerebral tumor.

The patient, Miss M. N., æt. 19, first presented herself at the office in August, 1879. She had been an invalid for a number of months and had received treatment from different physicians for a variety of diseases.

In December, 1878, she began to suffer from occasional attacks of vomiting, often preceded and generally followed by severe frontal headache. The vomiting was not dependent upon any gastric disturbance, her appetite and digestion were good, the vomiting occurring suddenly and unexpectedly. The attacks of vomiting and frontal pain became more and more fre-

quent in the course of the next few months. These two symptoms, together with occasional attacks of vertigo and general prostration, continued most prominent until July. During all this time there was no impairment of any of the special senses; general sensation and motion continued intact. Her memory and the expression of ideas also remained undisturbed.

In July she began to suffer from sudden paroxysms of dimness of visions; these attacks recurred at intervals of several hours, sometimes at intervals of three or four days.

They were generally connected with an exacerbation of the headache and the vomiting. The impairment of vision varied from a slight dimness and misty obscuration of surrounding objects to total blindness. At first, after the dimness or even complete loss of vision, her sight would return to a normal or nearly normal acuity of vision. But in the beginning of August there was already found a permanent impairment of vision in both eyes, more pronounced in the left eye than in the right, and in the latter part of August vision was found completely abolished in both eyes. At this time her hearing also became impaired and she complained severely of tinnitus aurium. The frontal and occipital pain, together with a sense of rigidity of the muscles of the neck and back, became more pronounced, the patient suffering the most excruciating pain. The vomiting during these last few weeks did not occur so often and she was able to retain her food. The general prostration became more marked at this time but the patient was still able, during the very brief intervals of pain, to walk across the room.

She never manifested symptoms indicative of a disturbance of the equilibration or coördination of muscular movements; general sensation or motion with one exception, i. e., a slight muscular tremor confined to the right side, and lasting but a brief time, were not disturbed. Her mental faculties also continued intact until death occurred. On ophthalmoscopic examination of the eyes (Sept. 1, '79), the pupils fixed and no response to light, refractive media clear. The characteristic alterations of optic neuritis were revealed in both eyes. The left optic disc was found in the transition stage and already showed signs of atrophic change. The margin of the disc was irregular; it was still swollen and of a bluish red color; the arteries reduced and the veins very tortuous and along their course numerous evidences of hemorrhagic effusion. In the right eye the swelling of the

dise was more pronounced; the retina also appeared swollen and infiltrated. The trunks of the blood vessels on the disc and in its neighborhood were obscured by the exudation; the arteries were very small and the veins varicose, and here also large and small hemorrhagic infarcta were found along their course. V=O d. The headache continued with unabating severity, the physical prostration also steadily increased and the patient succumbed to her excruciating sufferings without convulsive seizures or paralytic phenomena, her mind remaining clear to the last.

Post-mortem examination of the body of Mary Louise N., by Dr. J. C. MacKenzie, made 12 hours after death: Body not much emaciated and quite free from decomposition. Cadaveric rigidity well marked. At the vertex of the skull, an inch to the right of the sagittal suture, was a small spot, where the bone was deficient, the pericranium alone covering in the cranial cavity; and a similar condition existed at a corresponding point on the left side. Upon removing the calvarium, the depressions in the skull at these places were found occupied with pachionian bodies. The dura mater was less easily removed from the surface of the brain than usual; this was not due to any adhesions, but to the dry, sticky condition of the membranes. These were quite anæmic and the convolutions flattened.

In the posterior portion of the left hemisphere of the cerebellum was found a tumor, two inches in its transverse diameter, one and a quarter inches in its antero-posterior, and one inch in its vertical diameter. This caused a very marked projection of the posterior extremity of the hemisphere; it originated from the substance of the cerebellum, and not from the membranes, which passed over it unaffected. There was no line of demarcation between the tumor and the normal tissue, nor could it be enucleated; it was very firm, almost as firm as a fibrous tumor; in appearance it was semi-translucent, homogenous, and of a pinkish-grey color; at points there were small cavities in it filled with a clear fluid, the result of softening of the tissue. Above and anterior to this tumor was a cavity of considerable size, filled with a transparent fluid; this cavity was surrounded with cerebellar tissue, except at its inferior posterior portion, where it was bounded by the tumor; the lining membrane of the cavity was tolerably firm, and it was entirely isolated, having no communication with any of the ventricles or with the

sub-arachnoid space; the cavity, besides, occupying the interior of the left hemisphere of the cerebellum, extended into the superior vermiform process, but did not involve the right side at all. The lateral ventricles, the third and fourth ventricles, were very much distended, containing a considerable quantity of transparent fluid; there was, however, no softening of the walls. Other portions of the brain were normal. The other organs were not examined. The microscopic examination showed it to be granulation sarcoma.

I will leave this subject of the symptomatic importance of optic neuritis in the diagnosis of diseases of the brain, with but two further remarks. When neuritis is present, the degree of impairment of sight is by no means in proportion to the visible local alterations in the discs. Sometimes we see enormously swollen papillæ with very little defect of sight. In others, where the local nerve symptoms are slight the vision may be entirely abolished or nearly so. The effect upon the sight is evidently due to encroachments elsewhere, as in the optic tracks or visual centres, except in the advanced stages, when optic atrophy takes the place of the swollen papilla. The second is that marked fluctuations for better or worse in vision, as in the other symptoms, without any appreciable change in the appearance of the discs, and swollen papillæ may take place for years without very great damage to sight.

While neuritis of cerebral origin is nearly always double, it does not follow that double neuritis necessarily indicates brain disease. Neuritis and neuro-retinitis in particular, is often dependent on constitutional syphilis; Bright's disease; diabetes, etc., and then frequently affects both eyes, either at one time, or in succession.

In double neuritis, should there be an absence of brain symptoms, or a vagueness about them, we should turn our attention to the general diseases known to give rise to it. There is nothing characteristic about syphilitic neuro-retinitis, so far as the local symptoms are concerned, any more than in iritis, and we depend on the history, and symptoms elsewhere for the diagnosis. The same may be said of albuminuria, although the appearance of a group of dirty, white chalky looking opacities, in and around the macula lutea, arranged in a stellated manner, are usually looked upon as strongly significant of nephritic neuro-retinitis. Still it is not pathognomonic, as it occurs in retinitis

from other causes, and is not always present in the albuminuric form. In most cases that I have seen of retinitis albuminurica, this stellated chalky group of opacities, as seen by the ophthalmoscope, has enabled me to make the diagnosis of albuminuria without further inquiry, and before it had been suspected by the patient or his physician. I only have time briefly to state the conditions known to give rise to neuro-retinitis. First, syphilis. Second, kidney diseases, especially albuminuria. Third, lead intoxication — producing slight forms of neuritis, followed by atrophy. Fourth, all forms of meningitis, especially tubercular, — and encephalitis, and periostitis, at the base of the brain. All sizes and varieties of tumors, wherever seated within the skull. When intracranial diseases give rise to neuritis, there is usually very great oedematous swelling of the papillæ, while constitutional, and other causes are more apt to produce neuro-retinitis, with less swelling, and other alterations of the disc, and more in the retina, especially in the early stages. Sixth, it is claimed that neuritis, and neuro-retinitis are not infrequent as sympathetic diseases. That they are quite commonly found in injured eyes, with or without foreign bodies in the eye, I have frequently had occasion to verify in enucleated eyes. In these cases it is as a part of the irido-choroiditis, with more or less suppuration in the vitreous caused by the trauma or the presence of a foreign body.

Whether neuritis is ever seen arising in the uninjured eye as one form of sympathetic inflammation, without the presence of irido-choroiditis, is not fully settled. I believe it does, and Dr. Alt, and others are of the same opinion. Here is an eye enucleated last Friday, for confirmed and painful glaucoma in a man about 55 years of age, large, stout and of very florid complexion. Recently the other eye began to tire easily with some feeling of dimness of sight, which was still however, $\frac{2}{3}$; and on ophthalmoscopic examination, the disc was excessively red—in a marked condition of hyperæmia—but without opacity or oedema. The following morning, the papilla was less red, and his sight slightly sharper, and the eye feeling more natural. If neglected, which I could not afford to do, I believe that a genuine sympathetic neuritis would have developed. Seventh, neuritis is seen in all inflammations, and growths in the orbit, which lead to obstruction of the venous flow from that cavity to the brain. Eighth, attacks of neuritis or retinitis, now and then are

seen, where absolutely no cause for it can be discovered. So long as this is the case, we have to class them as idiopathic.

In conclusion, I only need to say briefly, that the characteristic symptoms of neuro-retinitis are of course ophthalmoscopic. Greater or less swelling, and prominence of the papilla, with blurring or complete obstruction of the vessels of the disc, with sudden bending of the veins, and great tortuosity and dilatation, with obliteration of the natural, sharp boundaries of the papilla, and more or less opacities, and hemorrhages on and around the disc, or involving the whole retina—are the diagnostic symptoms. Pain is but little complained of, and the sight is already more or less affected—more seriously when the retina is extensively involved, especially in its deeper layers, nearest the choroid.

ARTICLE XX.

ON THE INTRODUCTION OF FOOD AND MEDICINE INTO THE STOMACH WHEN THE ORDINARY CHANNEL IS OBSTRUCTED.* By FRED. HUMBERT, M. D., F. C. S., of Upper Alton, Ill.

Long after I had finished a paper on the above subject, I saw an item in one of our daily papers, which was to the effect that Miss Roxanna Bingham, a lady of Marlboro', Mass., who had positively refused to eat any food for nine days, died from actual starvation. She labored under the impression that it was wicked for her to eat; and, during her last hours, would not even allow attendants to moisten her parched lips. Her trouble was insanity; it had been coming on for several months.

Strange as this may appear it occurred in Massachusetts in 1880, where, no doubt, well informed physicians reside. In the same week I saw an account of a similar case in another newspaper. A woman in Cincinnati, Ohio, starved herself to death, believing that she had no stomach.

* Read before the Madison County, [Ill.] Medical Society, held at Upper Alton, Ill., January 23, 1880.

Nutrition is a most important factor in the treatment of disease, and if we cannot replace the waste in diseases of long duration, we must fail in effecting a cure. We must feed the patient with food containing much nourishment in a small bulk. Medicine can only correct the functions and destroy the germs of disease. To repair waste, food is necessary and we have no knowledge as yet of the manner of constructing protoplasm.

Among the difficulties presented in administering nutrition we find: 1st. Mechanical obstructions, such as foreign bodies, stricture and trismus. 2nd. Abnormal action of the nerves of the fauces, pharynx and œsophagus. Of the first class I shall only dwell on trismus, and of the second class, of the two conditions, the resistance to swallowing food and the rejection of all food that is introduced.

I can best explain the manner by which I introduced liquids into the stomach, without any surgical operation, notwithstanding the permanent closure of the mouth from lock-jaw, by describing a case. It will be new to most of you.

CASE I.—In the summer of 1842, I was called to a coal miner's wife, æt. 18, fully developed, and a bride of only a few days. She lay like a statue with a pale, expressionless face, the mouth contracted, the alæ of the nose elevated and the nostrils expanded. The eyes were fixed, pupils contracted and jaws fixed rigidly. The body was in a semi-rigid state, the surface warm, skin dry, accelerated pulse, slow respiration, and muscles contracted hard in the epigastric region. This tonic spasm commenced at 5 A. M., and had developed into a full tetanus.

Several physicians had called during the last twelve hours, and had resorted to injection, venesection, sinapisms and warm applications, without avail. They proposed to chisel out an incisor tooth to introduce medicine, but the husband refused. The remedies given were of no use, and the gravity of the case demanded that something decisive be done. Whilst thinking over the case I remembered having seen, in Missouri, a farmer fasten a rope to the head of a horse, and passing it over a beam, lift up the animal's head; another man poured medicine in the horse's nostril by means of a long-necked bottle. Taking the hint offered by memory, I lowered the head of the patient and poured, by means of a tablespoon on the lower edge of the nostril, a small quantity of a mixture containing three grains of tartar

emetic and twenty of ipecac in a glass of warm water. Whilst doing this I watched the side of the neck and noticed the peristaltic motion of the œsophagus, the fluid going down without resistance. I continued this at intervals of half an hour or more. I noticed an upheaving of the epigastric region and, shortly after, the patient rose abruptly, opened her mouth and ejected a large mass of fluid and undigested food. She stared at me with a vacant look. I continued the medicine by the mouth, for some time, to keep a state of nausea and relaxation.

From that time she returned rapidly to her former health, and continued so for two years, when she moved West, and I lost sight of her.

I believe, that in this case, there were two causes—*sordis gastritica* and irritation of the spinal cord, due to prolonged irritation of the peripheral sensory nerves of the sexual organs caused by copulation.

I observed in this case, that the nerves of the pharynx, and œsophagus were not irritated by the fluid running in through the nasal canal. I have, however, seen distinct irritation of the upper part of the œsophagus, preventing deglutition; of this I shall speak later. For the last 37 years, in cases of chronic inflammation, diphtheria, irritative or abnormal sensitiveness of the nerves of the isthmus of the fauces, I have introduced medicines and food through the nostrils in children and adults with happy results; nor was it necessary to continue this a long time.

CASE II.—In Feb., 1873, I was called to see a sick child, three months old. The grandmother, a very intelligent lady, had doctored the child several days.

The child had a very serious catarrh, which had interfered with its nursing for the last 24 hours; and, during the last 12 hours, it had rejected food as soon as introduced. The grandmother becoming anxious, had sent for me, to give relief if possible. I thought that the inflammation of the mucous membrane of the fauces was the cause of the sensitiveness of the peripheral nerves of the isthmus of the fauces, and that any effort through the mouth would be of no avail. Every five minutes I introduced, through the nostrils, ten drops of a mixture of half of a yolk of an egg in an ounce of milk, for a half hour, by means of a teaspoon. Next I tried to introduce this food by the mouth. To be certain of success, I irritated the lower lip with the point

of the spoon. I repeated the action of feeding with a spoon, until I thought that the nerve action of the fauces had been transferred by metastasis to the lower lip. Then I emptied the spoon, containing fifteen drops, into the mouth, and the child swallowed them.

This was repeated every five minutes for an hour. I directed fifteen drops to be given every ten minutes, and when I called the next morning, the baby had taken $5\frac{1}{2}$ ounces— $2\frac{1}{2}$ of yolk of egg, and three of milk. After this, the mixture was given at longer intervals, and in larger doses, and the child rallied quickly, and is now alive. The only medicine given was sulphate of quinine.

CASE III.—In the summer of 1876, I was requested to take charge of a lady, who for the previous four or six weeks had been under the care of a medical man for typhoid fever. The patient, *æt.* 50, was the mother of twelve children—nine living. During her whole married life she had been a sufferer from neuralgia in various forms. When I took charge of her, she was so weak that if she attempted to sit or stand up she would sink exhausted. She was in a very low condition. Her tongue was swollen, gray, dark red at the tip and edges, with raised papillæ. The fauces and pharynx were inflamed. She had an accelerated pulse, moderate temperature, constipated bowels, and talked incoherently, besides having delusions. She had taken but a small quantity of food for some time, and for the last few days refused it entirely.

The first indication here, was to sustain life with the richest food, over-balance the rapid waste, and improve the organs of deglutition. I had her head lowered, and introduced warm milk through the nostrils. At first she sneezed, then the fluid went down gently. When I had poured down five tablespoonfuls, I prevailed upon her to take it by the mouth. From that hour she was fed every fifteen minutes, afterwards every half hour, day and night, with a tablespoonful of a mixture of yolk of egg, milk and wine. During the first week, I gave her bromide of potassium, chloral hydrate and quinine, but no morphia, of which she had already taken too much.

After this I stopped all medicine, but the insomnia, of insanity, continued unchanged; I used chloral, bisulphide of soda, etc., and balsam of Peru as a mouth wash, to overcome the irritation

of the inflammation. In two weeks she was able to drink two tumblers of milk in twenty-four hours, besides being fed regularly every three hours. She increased in strength and with it her delusion increased to such an extent that a straight-jacket had to be applied at times. She was being continually corrected in regard to her delusion, and toward the fifth week, tried to act rationally at times; and, at the close of the seventh week, her reason was fully restored. All this was effected by proper feeding, and moral treatment. Her insanity was not hereditary, but induced by malaria and neuralgia.

I have said before, that I have only seen two cases of abnormal irritation of the peripheral sensory nerves of the upper part of the œsophagus. I shall only report my first case, which was more complete, and treated by simple remedies.

CASE IV.—In the Spring of 1852, I was called to see a lady, æt. 57, who had contracted quinsy, which terminated without suppuration. When all inflammation had subsided, all fluids and food were rejected. Her attending physician failed to overcome this. Believing that she would die of starvation, the patient requested to be taken home. The next morning after her arrival (March 9th) I was called in. Her condition was very debilitated, after two weeks' sickness and six days' fasting. The tongue, fauces, pharynx and œsophagus seemed normal except that the posterior wall of the pharynx and œsophagus were of a pale yellowish pink color. I thought a stricture existed lower down, or that the peripheral sensory nerves were not properly protected by the epithelium, and their extreme sensitiveness made the motor nerves cause food to be expelled. I swabbed the posterior part of the cavity of the mouth with a solution of tannin and alum.

The next morning there was no improvement, so I took a probang, fourteen inches long, with a sponge attached, dipped it in a strong solution of nitrate of silver, and swabbed the œsophagus as far as my instrument would allow. I passed it up and down several times, but found no obstruction, and desisted on account of the struggles of the patient. I then left to call in the evening, and repeat the operation. I felt convinced that I had to deal with an abnormal irritation of the nerves, accompanied possibly by hysteria.

A repetition of the operation was not needed, for when I returned the old lady was sitting up in bed, eating food with

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great relish. She continued to improve, and reached the age of 84.

The subject of this paper, which is somewhat prolix, has been from the beginning of this century, one of earnest thought among eminent medical men. Efforts have been made for methods to feed and give medicine to patients having lock-jaw. It is more important to day, to find methods of feeding those prevented from swallowing by disease, so that if possible we may sustain our patient whilst the cure is progressing.

Larrey, Chief Surgeon of the army of Napoleon I, and other French physicians attempted to introduced medicines by means of an elastic tube through the nasal canal. Every effort produced such suffocation that they desisted. Others recommended that an incisor tooth be chiseled out (I never saw it mentioned as having been attempted). Some again tried by introducing a tube into the corner of the mouth and behind the last molar tooth, but failed. [Copland's Diet.]

Cole¹ says, that attempts had been made to separate the jaws gradually by means of wooden wedges. He also mentions feeding by means of a tube through the nose. Bauer¹ says it is rational to introduce food through the nostrils; Erb also, but neither mentions the fact of its having been done.

Clement Dukes,² M. D. B. S., London, M. R. C. S., London, used the following device for children: He introduced in the nostrils a rubber tube of one-eighth inch bore, to whose extremity a ball of a half pint capacity was attached. By alternately compressing and relaxing the tube the fluid in the ball escaped in the œsophagus.

Krug³ recommends feeding by sub-cutaneous injections. However, the one approaching most nearly my method is that communicated by Andrew Maxey,¹ M. D., D. M. R. C. P., who recommended and practically carried out the introduction of food and medicine through the nostrils by means of a funnel.

Another communication² by him appeared under the caption, "Feeding by the Nose, in Attempted Suicide by Starvation," in which he stated that his plan was but little known, or at least but little tried by the bulk of the physicians.

Dr. Tennent³ and Dr. Hitchman⁴ are in favor of nasal feeding

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| 1. Ziemmson's Encyclop., 1874. | 2. London Lancet, 1876. |
| 3. Wiener Wochenschrift, 1876. | 1. London Lancet, 1869. |
| 3. Glasgow Med. Journal, Nov., 1876. | 2. Ibid, 1873. |
| 4. Report of Derbyshire Co. Insane Asylum for 1871. | |

in the case of self-imposed abstinence among the insane. Dr. Maxey once said, that notwithstanding the publicity of the method of feeding there was a murderer balking justice by starving himself to death, when all that the officials had to do was to lay him on his back, put a funnel in one of his nostrils, and fill his stomach.

This comparative forgetfulness of the subject induced me to read this paper to you. It is a most important part of our therapeutics in many diseases, before which we often stand helpless. To impress upon you the manner of using this simple means of reclaiming many a life on the brink of a grave has been my task.

ARTICLE XXI.

A CASE OF TRIGEMINAL NEURALGIA CAUSED BY SYPHILIS.* BY
EDWIN WALKER, M. D., of Evansville, Ind.

Andrew Joyce, æt. 51 years: American; steamboat mate. Applied to me for treatment October 10th, 1877.

HISTORY.—He stated that he had suffered from severe neuralgia of the right side of the face since 1870. In that time he had never passed a whole day without some pain. He was always worse in wet and changeable weather, and at these times the pain would become so severe that he was confined to the house, and was unable to sleep for forty-eight hours or longer, unless under the influence of an opiate. These attacks would last, with more or less severity, as long as the weather continued unfavorable, in some cases two or three weeks. The pains were not worse at night.

Otherwise, his health was good, but he did not feel so well as formerly. He lived a hard, exposed life. Said he had used spirituous liquors moderately, but never to excess. He had, up to the present illness, been strong and rugged. The only disease he had ever had was syphilis, of which he gave the following history: In 1847, he had a sore on his penis which remained several weeks; it was accompanied by a bubo which did not suppurate. His physician told him he had syphilis, and gave him internal treatment for some time.

He does not remember how long, nor does he know what he took. Can not remember having any cutaneous eruption, until two years later, when a pustular eruption appeared, which left scars, retaining a reddish-green color for some time.

It occurred, at intervals, for two years, during which time he was treated for syphilis. In 1855, hard, roundish, bluish-red elevations (tubercular syphilides (?)), which were very chronic, remaining a long time in spite of treatment. About this time, an offensive discharge from the right nostril commenced and has continued ever since.

In 1858 or 1859, nodes appeared on both shins. Had noctur-

* Read before the Tri-State Medical Society, 1879.

nal pains, from time to time, until 1866. During this time he was treated for syphilis.

From 1866 to 1870, he took no medicine. Nodes remaining, but causing no pain. In 1870 he had his first attack of neuralgia. It followed an exposure in cold rainy weather, and since that time he has suffered with attacks of the same character up to the present time. He had taken many kinds of medicine, none of which gave him any relief, except opiates in large doses. He has taken no anti-syphilitic treatment for the neuralgia, every physician he consulted assuring him that syphilis had nothing to do with it. He does not know whether, at any time, he has taken mercury; he has never been salivated. Never had rheumatism in any form. None of his relations, so far as he knows, ever suffered from neuralgia, epilepsy or insanity.

He is, for his station in life, a man with strength of will, and not inclined to give way easily to his malady.

When he came to my office he was suffering with a severe neuralgic attack. He stated that he had not slept for forty-eight hours, and that one-half grain doses of morphia sulphate every hour had failed to give him relief. The pain came on in paroxysms, at intervals of from three to five minutes, and would last from twenty to thirty seconds. The paroxysm would come on without warning, often while the patient was talking. The least current of air would bring it on.

The pain was agonizing, making him fairly writhe, while the face was contorted into terrible grimaces by uncontrollable spasm of the facial muscles of the right side. There was also marked blepharospasm. He would rub his face hard with his hand until the pain stopped. Then he would be entirely free from pain until the next paroxysm.

The pain started on the malar bone, rapidly extending throughout the entire region supplied by the trigeminus. The usual tender points were found, at the supra and infra-orbital and mental foramina, and in the malar region. There was entire absence of taste and smell on the right side. There seemed to be complete anæsthesia, and analgesia on the right cheek; these were not so well marked on the forehead. There was no paralysis of any muscle. The right cheek appeared drawn as though the muscles might be contracted. He uses the right cheek much less than the left in talking, but this is probably due to fear of producing pain.

His teeth were examined both by myself and a competent dentist, and we found them entirely sound, excepting two lower ones that were loose, but not decayed; they were pulled. He had never lost but one, and that was pulled when sound with a hope that it might relieve him. The second molar of right side was a little tender when pressed upon.

In view of the undoubted syphilitic history, it was thought best to try anti-syphilitic treatment. He was put upon the potassium iodide in 20 grain doses every four hours.

The next day he reported himself better, but still had some pain. Two days later, he was entirely free from pain. He continued the potassium iodide in 20 grain doses, with $\frac{1}{16}$ hydrarg. bi-chlor. three times a day for about one month, when I lost sight of him.

On January 2nd, 1878, he came to my office, suffering as severely as at first. He stated, that two nights previous he got very wet, and from that time had suffered as he does now. Before this attack he had suffered none since last report. He was ordered to resume the potassium iodide as at first (20 grains every four hours).

On January 5th he reported himself entirely relieved. The potassium iodide and hydrarg. bi-chlor. were continued as above. January 24th, has had no pain since last report; the discharge from the right nostril is a little more than usual. Treatment continued. February 16th, has a little pain of neuralgic character in lower jaw, but without spasm the last two days. This is the only pain since last report. He has improved much in general health, having gained twenty-eight pounds since January 1st. Treatment continued as above.

Our patient again disappeared, and I did not see him again until the 27th day of May. He was suffering with pain and spasm, but it was not nearly so severe as before. He had taken no medicine since last report, having been entirely free from pain. I gave him 15 grains of the potassium iodide every hour. The attack being less severe, I concluded to try a smaller dose.

May 30th—A little better but still has some quite severe pain. Ordered him to double the dose.

June 1st—Much better, but not entirely relieved.

June 4th—Has two or three attacks a day, not quite so severe. June 7th, has had no pain to-day or yesterday; feels much better. Was put on the same treatment as above, which

he continued for several weeks, when he again disappeared.

The patient, gentlemen, is before us.

Since last report he has had but two very slight attacks, not lasting over two hours, and both passed off without treatment. He says he feels entirely well. If you notice, the same drawn appearance of the right cheek remains, the cheek entirely recovered its sensibility, and taste and smell are as good on the right side as on the left.

I think in this case the diagnosis of neuralgia of syphilitic origin is justifiable.

The unequivocal syphilitic history, and the absence of rheumatism or other recognizable cause, together with the result of the treatment, render the diagnosis almost certain. I am aware that sometimes severe trigeminal neuralgia disappeared for a time without treatment or known cause, (Anstie on Neuralgia, page 44).

It is hardly probable, however, that relief during anti-syphilitic treatment could have been accidental three successive times. The relief took place in each instance, in about the time it requires to relieve other tertiary syphilitic pains; and in the third relapse, while a smaller quantity was given, relief was incomplete. and when the dose was increased improvement soon followed.

Huebner, in speaking of the symptoms of syphilitic neuralgia (Ziem. Cyc. Vol. XIII, pages 357 and 362), says: "With the exception of nocturnal exacerbations of pain, there are no points of difference between this affection of the trigeminus and non-syphilitic diseases of the nerves." And of diagnosis he says, "With regard to the peripheral nerves, when these are the seat of neuralgic affections, the principle weight must be laid upon the nocturnal appearance of the attacks."

In this case, there were no nocturnal exacerbations. I do not think the latter are essential to the diagnosis, since in many of these cases the connection of neuralgia with syphilis is merely accidental, and the symptoms are the same as would be produced by similar interference with the function of the nerve by any other morbid process.

Bumstead, in speaking of syphilitic neuralgia, says (page 633), "The pain * * * * occasionally undergoing nocturnal exacerbation, but not presenting any decided specific character, is the most frequent symptom." The only case resembling this one, which I have been able to find in the books and journals to

which I have access, was one reported by Anstie to the Clinical Society of London in 1872.

This was a case of neuralgia of the third division of the fifth pair excited by syphilitic infection of a recent date. The patient was a man who had suffered with migraine on the same side on which the neuralgia appeared. The tender points were the same as in ordinary neuralgia.

There was unilateral facial anæsthesia, loss of taste and spasm of muscles. The case was exactly like ordinary neuralgia, not due to syphilis. It was also accompanied by paralysis of some facial muscles.

The neuralgia was promptly relieved by potassium iodide 30 grains three times a day, but the paralysis was much more obstinate; later in the disease iritis was developed. Some difference exists among authors as to the frequency of syphilitic neuralgia. Bumstead says (page 631): "The affections of nerves met with in the secondary stage of syphilis consist chiefly of neuralgia." Fournier (*Leçons sur la Syphilis*, 1873, page 774) concludes that secondary syphilis is a tolerably frequent cause of neuralgia. Neither of these authors speak of the frequency of neuralgia from tertiary syphilis. Hammon mentions syphilis as "A very common cause of neuralgia."

I think the statements of these authors would lead one to suppose it to be a more common factor than it really is. Erb (*Ziem. Cyc.* Vol. XI, page 31) warns us, with good reason I think, not to confound neuralgia with the "*Dolores osses carpi*," so common in syphilis. This error has, I think, led to the opinion that syphilitic neuralgia is of more common occurrence than it really is. The rarity of reported cases in the journals and my own experience lead me to regard the view of Anstie, which I quote below, as more nearly correct. (Anstie on Neuralgia, page 175.) "As regards the relation of syphilitic dyscrasia to neuralgia I agree, in general with Eulenberg. '*Syphilis*,' he says, 'may be the direct cause of neuralgia, either by the development of specific gummata in the nerve trunks or in the centers,' or by arousing chronic irritative processes in the nerve sheaths or membranes of the brain and spinal cord, or especially in the bones and periosteum (syphilitic osteitis and periostitis). The case periostitis, however, is a doubtful one; it may be questioned whether this affection ever gives rise to true neuralgia.

Persons who are by inheritance highly predisposed to neu-

ralgia, may, from the mere general lowering of the health, produced by constitutional syphilis, become truly neuralgic simultaneously with, or subsequently to, the appearance of painful nodes on their bones. And as regards the whole relations of syphilis to neuralgia, I must from my experience conclude that the former is, after all, but rarely concerned in the production of the latter. Syphilis has a specialty for producing limited *motor* paralyzes but a much weaker one for producing limited affections of the *sensory* system. To localize the lesion in this case is quite difficult. Such a neuralgia might be caused by a lesion of the central origin of the nerve, by irritation of some of its peripheral branches or by involvement of the nerve trunks. While it is possible, I do not think it at all probable that a lesion would confine itself to the origin of the fifth nerve and not affect any of the neighboring nerves. Nor do I think such a profound anæsthesia and loss of taste and smell would be likely to accompany a neuralgia caused by irritation of the peripheral branches. The disturbance of the ophthalmic division was much less than that of the other two. I do not think any lesion external to the cranium would be likely to affect, so profoundly, the second and third divisions of the fifth. It seems to me therefore that it is by far the more probable that the lesion involved the nerve trunks of the superior and inferior maxillary division in their intra-cranial course. For it is possible for a lesion in the middle fossa of the skull to affect these without involving any other nerve. While, at first, I was inclined to give importance to the nasal discharge as a means of localizing the lesion, on more mature reflection I am inclined to think the discharge was produced by an altered condition of the Schneiderian membrane caused by the interference with the function of the fifth. To determine exactly what the lesion was or whether it was one of those cases in which no palpable lesion can be found, is still more difficult. The stage of the disease, together with the persistence of the symptoms, render the latter improbable. Van Buren & Keyes, (page 648,) say, "It is common in cases of nervous syphilis occurring within a few weeks or months of chancre, where death has ensued in consequence of nervous malady, or been occasioned by inter-current diseases, to fail to discover any material lesion, whereas death from nervous syphilis occurring late after general infection, is almost uniformly on autopsy found to be connected with material lesions." The lesions in

this case may have been either of the following, which seem to me to be about equally probable.

Neuritis caused by compression of the nerve in its intracranial course by a gummatous tumor of the membranes; or infiltration of the nerve extending from the same; or lastly "A primary syphilitic affection" of the nerve, that is, syphiloma or gumma of the nerve or syphilitic neuritis, as described by Heubner (*Ziem. Cyc.* Vol. XII page 352-4). This case presents several points of great interest. The absence of any family neuroses is important, since such severe neuralgias rarely occur in those not predisposed. The anaesthesia is interesting in that it corroborates Anstie's view that "Pain is not a true hyperaesthesia; on the contrary it involves a lowering of true functions"—the loss of smell by the disturbance of the function of the fifth corroborates what experimental physiology has already proven, that destruction of the fifth nerve creates such changes in the Schneiderian membrane as to destroy the sense of smell. So satisfactory a result in a case of so long standing could hardly have been expected. Not only was the neuralgia completely cured but there was a return of the functions of the nerve; taste, smell and general sensibility being restored. It has now been nearly eighteen months since the last attack.

Proceedings of Medical Societies.

ST. LOUIS MEDICAL SOCIETY.

Supernumerary Nipples.

SATURDAY, JUNE 5th, 1880.

DR. HURT reported the following case: This case may be called a case of supernumerary nipples. After her confinement a month or so ago, the patient complained of sore nipples, and on examination I found the areola to be studded with quite a number of what I supposed to be warts, and, after prescribing, I suggested to her that she ought to be very careful, for if she got these warts inflamed they might give her trouble. She replied that they were not warts. Said I, "What are they then?" "They are little nipples," said she. I asked her why she supposed this. She answered, "Because whenever I nurse my child they have a little drop of milk on them." I felt so much interested, that I instituted an examination and both she and myself could squeeze milk out of these little protuberances around the nipple, and she said when her breast is very full that all of the nipples commence secreting. I questioned the fact because I have never noticed anything of the kind, and I do not believe I have ever read of anything that would form a parallel to this case.

DR. COLES—Were these points or nipples outside or inside of the areolæ?

DR. HURT—They were beyond the margin of the ridge of the central nipple, but within the colored area, which is not larger than is common with a woman who has a full breast. They seem to be so many little milk glands. I suppose the lady is an excellent nurse. They do not diverge sufficiently from the central nipple to cause anything like a waste of nourishment intended for the child. They are not shaped like a wart but like a virgin nipple, and look a little redder than the skin of the areola.

DR. POLLAK—Is she nursing?

DR. HURT—Yes.

DR. MONTGOMERY then read a letter from his brother, the Rev.

Montgomery of——, Ireland, in which he gave the history of an attack with which he had been afflicted, and which bore a striking similarity to the one from which the doctor himself recovered recently.

Dr. Montgomery then continued: It is remarkable that the above sickness of my brother should be so similar to my own. Our attacks occurred about the same time; the probable causes were the same, the mode of accession, the phenomena exhibited during the course of the disease, its subsidence and the means employed to combat it were all nearly alike.

The supposed causes, anxiety, too close attention to work, a constant and monotonous tread-mill labor of mind and body, irregularity of food and exercise etc., were identical. The symptoms, lassitude, lethargy, dullness and a lack of all energy and ambition, headache, vertigo, loss of memory, disturbed sleep, indifferent appetite, etc., were the same in both cases, and what seems most strange is the fact that early in the disease we both became partially delirious.

The remedial measures which I thought relieved me were administered by his physicians. The only sanitary measure which he was deprived of, I believe, was the great source of my speedy and wonderful recovery, namely, the waters and hot baths of Hot Springs, Arkansas. I do not wish to be considered an enthusiastic admirer of Hot Springs, as I saw many there laboring under various diseases who did not seem to be benefitted by their abiding there; but in all of the three visits I paid, I was each time most wonderfully bereft of all my bad symptoms in a short time. Each time I went to these springs I was afflicted with languor and lassitude, violent headache every day, great vertigo, an apparent want of power and a staggering of my lower extremities, anorexia, sleeplessness, loss of memory, with great depression and despondency. These outward conditions left me each time after three or four days employment of the waters and hot baths.

I should remark that we are of a race of very healthy and long-lived people, and I have never heard of any of our ancestors being afflicted with any disease of the brain or nervous system. Our father and mother died at the age of 95 and 85 respectively. My maternal grandmother lived until she was 113 years old.

DR. MAUGHS suggested as the best remedy for the patient, a prolonged rest, and that Mr. Montgomery visit his brother, the doctor in America, and follow the same treatment which had proven so beneficial in the Doctor's case—a course of bathing, and hygienic life, at the Hot Springs, Ark.

DR. HUGHES suggested the same course.

DR. JOUNSTON concurred with Drs. Hughes and Maughs. He also stated that it was his opinion that the trouble in Dr. Montgomery's own case, was due to malarial influence, in a great measure; because, if there had been any change in the structure of the brain itself the improvement in the case would not have occurred. He attributed the case to malarial influence combined with overwork of the brain.

DR. HUGHES—It seems to me the Hot Springs is a very excellent place for overworked brains. A man may have neurasthenia of his ganglionic nervous system and it may go to such an extent that he ceases to appropriate from the blood the necessary elements for its recuperation and repair. The patient may be possessed of a circulation which is rich in all the elements necessary to reconstruction, and yet by reason of inadequate rest of the parts he may reach a condition of exhaustion by which the nerve centers will not appropriate from the current of the circulation the elements essential to their reconstruction, and it is only upon such an hypothesis that we can account for the rapid benefit, which occurs in these cases, when they take a voyage and suspend the customary tax made upon the brain. It is highly probable that a condition of absolute rest, if there be no organic lesion here, will be sufficient to bring about a restitution of nervous force. It is the height of folly to expect a patient, a professional man whose brain is exhausted, by professional labor in which the small hours of the night are encroached upon, to recover his bodily energies whilst continuing his labors. A very large part of the success of practitioners of great reputation in the treatment of debilitated nervous systems is due to the fact that their patients come to them under the most favorable circumstances for recuperation; they come to them free from the daily tax upon them, that has brought about the exhausted condition of the organism of the brain; of the cerebral and spinal nervous system. And we find such physicians receiving credit for performing cures which Nature

achieves herself. Of course, if degenerative changes have taken place, it would not be likely that recuperation would follow.

Obstruction of the Bowels.

DR. PREWITT—I have recently met with two cases of obstruction of the bowels which I thought might be of some interest, and worth while to report. On the 30th of April I was called to see a man, about 27 years of age, who had been taken several days before with pain in the bowels, nausea, vomiting, obstinate constipation and a good deal of prostration, the pains being paroxysmal. I think he was taken ill on Monday and I saw him on Friday night. During the whole of that time he had been having paroxysms of pain in the bowels, and vomiting, with considerable fever. The physician who had been in attendance in the early part of the attack stated that there had been no fever for the first two or three days.

There was no tenesmus, no desire to go to stool. After investigation, I became convinced that it was a case of obstruction, due either to a twist in the bowel, an internal hernia or a band of adhesion constricting the bowels somewhat. Now, while it is impossible in a case of the kind to say what is the special obstruction, we might be able to approximate a diagnosis in that respect. It was certainly not a case of intussusception, it was certainly not a chronic obstruction; it was certainly not due to a gradual constriction of the bowels, for it was sudden. In this case I thought it was most likely a twist of the bowel, because this is the most frequent cause, where we can exclude previous inflammatory action as inducing adhesive bands or where we can exclude old hernias which might lead to bands of adhesion so that I made a tentative diagnosis, as it were, of twist of the bowels.

Again, I inferred that it was probably at the ileo-caecal junction. I stood the man on his head with the view of allowing the small intestines to fall back and so obtain partial relief. The man insisted that he was relieved; I repeated this a second time, but the relief was not complete, and it was evident that something must be done for him or he certainly would die. I suggested, as a last resort, laparotomy, though under very unfavorable circumstances, because the symptoms had lasted for such a length of time that it was evident inflammation had occurred. His friends were not favorable to the proposition, so that it was not carried out immediately, and the Sunday morning following

seeing a persistence of the case and an evident fatal termination pending, they gave their consent. With the concurrence of the attending physician, and also of Dr. Gregory, I operated. I opened the abdomen in the median line, and after opening the peritoneum there was a large quantity of lympho-purulent material, several ounces at least, with quite a fecal odor, and it suggested the possibility of a perforation of the bowel. This did not occur immediately on the opening of the abdomen, but after examining for the ileo-cæcal junction, and seemed to result from the breaking up of some adhesions. I suspected that possibly the bowel had given way at some point from softening by inflammatory processes.

After a hurried consultation I concluded that it was well to make an opening in the bowel above the site of the obstruction so as to form an artificial anus. This was done in the left iliac region, and a coil of distended small intestine was opened and tacked to the margins of the opening, while the incision in the median line was closed and properly dressed for union by first intention.

There was a certain amount of relief so far as the symptoms of obstruction were concerned. He rallied; his pulse grew better. I think it was barely possible, if the whole abdomen could have been cleared out from this material, that the success of the operation might have been complete. But he died after two or three days from the effects of the peritonitis. I secured a post-mortem and upon opening the abdomen and carefully examining I found that there was a twist of the bowels; that in the small intestines, the lower part of the ileum had become twisted upon itself in such a way that it hung down into the pelvis and constricted quite a mass of the ileum.

There were portions of it that were very dark, of a deep purplish red. The lesson which that case taught me was not that the operation ought not to be performed in these cases, but that it ought to have been done much earlier; or that, if any operation were to be performed at that time—after the establishment of such an amount of peritonitis—it would have been better to have contented ourselves with making an artificial anus in the bowel above the point of obstruction. It would be almost impossible to get at the obstruction without running the risk of tearing the bowel which was softened by inflammatory action. I think it is possible, had the nature of the case been recognized

before inflammatory symptoms had become so marked, and laparotomy had been performed then, that this portion of the bowel might have been untwisted; it might even have been relieved at an earlier period by standing him on his head, and so allowing this mass of twisted bowel to fall back and become relieved. I have several times met with just such a condition of things in post-mortems, where I believed this procedure might have been successful.

The other case was one to which I was called on May 22. The patient was a man 26 years of age, a stout, able-bodied German. He stated that about two weeks before, in lifting a wagon, he had hurt his back and side. I do not know whether there was any connection between the symptoms that followed. I saw him on Friday the 22d. On Thursday he was up in Bremen and called on a physician there, who had treated him on a previous occasion for some trouble which he said was inflammation of the bowels. Whether he meant that the patient had diarrhœa or peritonitis I do not know, but he called it inflammation of the bowels, and stated that he was in bed for it six weeks, two or three years before. I could trace no connection between the previous attack and this pain. You know, Mr. President, that it is not infrequently the case that a peritonitis is followed by a condition of chronic obstruction of the bowels, which become matted together, and the peristaltic movement being thereby greatly diminished, constipation results. But I could trace no connection with this former attack, nor with the straining of two weeks before. But on the previous Thursday he had complained of pain in his bowels, and went to the physician who had treated him before and who evidently had given him some doses of calomel. His bowels had been moved that Thursday morning, but they had not been moved after he took the purgative, and he had a good deal of pain. During Friday he had nausea and a frequent desire to go to stool. The stools were small and bloody. When I saw him on Saturday morning I made a diagnosis of intussusception of the bowels. I could find no tumor; the man was of rather full habit, and it would have been difficult to discover any tumor in connection with the bowels in his case. I used injections of water. These seemed to give him a little relief, but it was not complete, and after two or three hours I resorted to inflation of the bowel, and blew him up until he complained of a great deal of pain. I

made up my mind to perform laparotomy unless there was a relief of the symptoms. I gave him bismuth, hot fomentations, and used the ordinary methods to relieve the over-action of the bowels. It was about 1 o'clock when I resorted to inflation, and about 4 o'clock I visited him again with one or two other medical gentlemen, with the intention of operating if the symptoms remained still urgent; but I was very glad to find that the urgent symptoms had subsided. He had not vomited more than once, the pain was less, and there had been no further tenesmic stools. I saw him about 6 o'clock, when he had had a copious operation of the bowels, almost a quart he said, of dark fecal matter. At that time recovery was progressing favorably; but he was very badly salivated. The calomel which he had taken could not act until the obstruction was relieved.

These two cases illustrate very clearly two of the forms of acute obstruction of the bowels, and illustrate also, I may say, the treatment proper in these cases. In intussusception we may hope to accomplish something by large injections, or what is better, inflation, because in that way we may hope to induce the invaginated bowels to recede, and relieve in that way; but in case of internal strangulation from any other cause, inflation and large injections of warm water can only do harm, and a great amount of mischief may result.

Some years ago, in a case of what proved to be a twist, I inflated the man's bowels. He became rapidly worse, the symptoms more and more urgent. In fact, I had intensified the obstruction of the bowels by distending the abdomen, and causing the constriction to be that much greater. The patient died, and I made a post-mortem, and found a very thorough twist of the ileum, and a mass of twisted bowels hanging over the pelvis, constricting the lower portion of the ileum, while the folds of the twisted mass itself were thoroughly strangulated. In that class of cases injections and inflations will do harm. They aggravate the local symptoms, and certainly hasten the appearance of peritonitis. But in intussusception, we may resort to injections with a prospect of doing some good, especially if it be done at a period before peritonitis has set in. After the invaginated portions have become adherent, and perhaps begin to slough, if we use such procedure we ensure the patient's death. The view I take of these cases is, that in the inception, we must deal with them as with hernia, and whenever we have failed by the

ordinary means that we should adopt precisely the same rule that we do in hernia. It is a well established rule, in hernia, that when we have failed by the ordinary means of reduction, it is the duty of the surgeon always to operate; and it is our duty to endeavor to relieve this condition of things if possible by the ordinary method, and if we fail then to operate.

DR. MONTGOMERY opposed the practice of administering purgatives in these cases, and said: It certainly tends to produce peritonitis, a thing always to be dreaded in these cases, where intussusception or stricture exists. It is best to use such remedies as produce relaxation and nausea. As regards surgical procedures, I agree with Dr. Prewitt, that in the first stages they may relieve; but they are dangerous, and often fatal. A good deal can be done in these cases by early treatment. Drastic purgatives should be avoided in the early stages.

DR. NEWMAN—This is a very interesting matter, because the disease is a dangerous one, and the diagnosis difficult. If we could be always satisfied as to the diagnosis in these cases, we could be ready to decide as to the proper line of treatment, and Dr. Montgomery's would be correct. But we know that it is very often the case, that these obstructions are due to the accumulation of large masses of fecal matter and, in such cases, the best means of relieving them is perhaps by irrigation. But we can very rarely tell what are the true conditions existing in the disease. I have had considerable experience in these cases, and I am convinced with Dr. Prewitt, that although this operation is often too late to effect the improvement intended; still, under the improved surgical procedures with antiseptic measures, it is not so dangerous as formerly. It has been recommended by eminent surgeons, and Dr. Prewitt's case would have been a success had it been entered upon at an earlier period. If we are called upon to see a patient in a case of obstruction, and give purgatives, and it should turn out that the patient had intussusception instead of obstruction, we could not be censured, because under these conditions we pursue a line of treatment which is the best we can be acquainted with. I recollect a few years ago, a case in which I resorted to inflation, supposing it to be a case of intussusception. The patient, who was a very obese woman, recovered. Some time since I had a case in which the symptoms were quite similar, in which we suspected

intussusception, and resorted to inflation, as suggested by Dr. Prewitt, and I think we did our patient great injury.

DR. PREWITT—Fæcal accumulations do not produce symptoms of obstruction until inflammation has set in—that is what we have to combat,—and we cannot give purgatives of any sort without running the risk of aggravating the mischief. It is not the fæcal accumulations which give rise to the symptoms of obstruction, but the inflammation. I think that in no condition in which we have obstruction of the bowels, are we justified in using purgatives. It is like an attempt to force out the cork from a bottle within by distension. We can empty the bowel much more readily by injections than by purgatives. More than that, whenever we have symptoms of obstruction, there already exists an excessive peristaltic action above the point of obstruction, and we simply goad the already excited bowel by the administration of purgatives; and we certainly determine the onset of inflammatory symptoms, so that I am willing to stand by the broad statement, that there is no *possible condition of obstruction that admits of the use of purgatives*. They can do harm only, and are always pernicious. We hear occasionally of cases in which quicksilver—liquid mercury—is given. In these days this is gross mal-practice. As to the obscurity of these cases, although we may not be able to say, that it is internal hernia, or adhesions, yet we may conjecture from the history of the case, and approximate it at least. Then I take it, we ought not to be often mistaken in discriminating between intussusception and acute obstruction. In intussusception, symptoms of obstruction exist, but we have in addition tenesmus, dysenteric symptoms; if these are absent, we can say with almost absolute certainty, that it is not a case of intussusception. In addition to that, in many cases, we can discover the existence of tumor. Then we may determine oftentimes whether we have a chronic, or acute case of obstruction, and this is often of immense value in the diagnosis, prognosis and treatment.

In all cases, obstructions may be divided into two great classes—chronic and acute. Chronic obstructions may be either of the large bowel or of the small one, and all pathological anatomy shows us that when the large bowel is involved in a chronic obstruction, it is a stricture due to cancer, or an inflammatory constriction of some sort; that in an immense propor-

tion of cases—90 per cent. of all the cases of chronic obstruction of the large bowel—it occurs between the sigmoid flexure and the anus. Occasionally there is cancerous obstruction higher up, but these are exceptional cases. Chronic obstruction of the small bowel is usually due to old peritonitis, resulting in the matting together of the intestines; and then, there are the characteristic symptoms which result from an interference with the peristaltic action of the small intestines, running over a period of years, and terminating, perhaps, in acute symptoms. Whenever there is chronic obstruction of the large bowel, there is in addition difficulty in defecation. By means of these and other differences, we can distinguish with almost perfect clearness between obstruction of the large bowel, or of the small intestine, in these chronic cases. Then, when we have excluded cases of chronic obstruction, we have acute obstruction, and here again clinical experience gives no uncertain sign as to the probable nature of the difficulty.

DR. JOHNSTON—What is the difference between the symptoms in intussusception and obstruction?

DR. PREWITT—The symptoms of obstruction of any kind are always the same; there is the nausea, the vomiting, the prostration, the paroxysmal pains, and the obstinate constipation. In intussusception there is in addition the tenesmus, the small bloody mucous stools without fecal matter, and oftentimes in addition still there is found the sausage-like tumor.

DR. NEWMAN—The necessity of emptying the bowel is self-evident. Dr. Prewitt opposes the use of purgatives, and advocates the use of enemas. But how often is it not the case that these enemas are almost useless, producing nothing but an emptying of the rectum. Then, how often in dysentery, where the patient is passing mucus and blood for days at a time, and the upper portion of the bowels never have been emptied, the administration of purgatives is advised by very high authorities. I have often seen cases in which fecal matter was passing freely from the bowel in a fluid state, and upon the administration of a purgative, large accumulations have been brought away by the action of the bowels, of masses so extremely hard that it was necessary to use a spoon to remove them. I think Dr. Prewitt's view unfortunate, because when we go to these cases we do not know whether they are from obstruction or some other cause.

I have been associated with the Doctor in several cases, and I think we both found difficulty in the diagnosis. I was very much struck, Mr. President, with the remark of our celebrated countryman, Emmet, in speaking of things of this character, in which he speaks of these difficulties as existing only in the imagination.

SATURDAY, JUNE 19TH.

An Obstetrical Case: Intra-Uterine Amputations.

DR. COLES.—I will relate a case of unusual interest both in an obstetrical and teratological point of view. On Tuesday, June 1st, I was called to assist Dr. A. M. Powell, of Collinsville, Ill., in a difficult case of labor. The patient was a primipara, æt 21, in whom pregnancy had progressed normally. It appears that on Sunday afternoon, May 30th, she had taken a drive, and fearing some breach in the harness, she got out of the vehicle and walked up a long hill; that night active labor pains set in, rather to her surprise, as she had not expected to be sick for ten days or more. The early pains were of such decided and vigorous character, that there was every prospect of favorable progress. In a few hours, however, the uterine contractions became irregular and unsatisfactory, and so continued throughout the labor.

I saw the patient about 7 P. M. Tuesday, and found that the membranes had ruptured twenty-four hours before; the head was still high up, the os far back and dilated to the size of a dollar, thick, but not rigid. The pulse was quite excited, and the patient showed signs of failing strength, though she had been very judiciously managed by Dr. Powell, who had administered nourishment and procured all the rest practicable. For over forty hours the pains had been far apart, very short and feeble, so that little progress had been made, considering that the pelvis was ample—the head not having at this time become really engaged. It was decided to give a moderate dose of ergot and await developments. The effect of the ergot was to improve the pains and increase the dilatation of the os, so that in the course of three hours the vertex (which was posterior) had descended sufficiently to render application of the forceps feasible. Being satisfied that there would be no delay in delivery, it was deemed prudent to precede the use of instruments with a second dose of ergot, with a view of overcoming the excessive uterine atony

which had been a marked feature in the case, and thus guarding against hemorrhage when the uterus should become empty. As soon as the ergot began to act, I applied Hodges' forceps, and a healthy female child, weighing about six pounds, was delivered, without any force being necessary. The uterus contracted well, and there was no sign of external hemorrhage. I say the uterus contracted well, for it was quite hard and firm, yet it was somewhat larger than it should be only to contain a normal placenta. Suspecting the possibility of concealed hemorrhage, I passed my hand up within the cervix, and was surprised to recognize a second child; my finger came in contact with a relaxed membrane, and through it could be distinctly felt the parietal bone of a fetus. This bone was exceedingly movable, so much so, that it could be easily pushed in with the finger. The size of the uterine body was such that it seemed almost incredible that it could contain a fully matured fetus and two placentae. There was nothing to indicate that there was another child on external palpation, the uterus was uniformly round and firm, not extending above the umbilicus, and through its walls no outlines of a fetus could be detected; there was no fetal heart-sound.

Dr. Powell also made a digital examination, and he agreed with me that the remaining fetus was dead, and that it was imperfectly developed. And while it turned out that we were correct in this opinion, yet the weight of the child proved to be much greater than we anticipated,—we having been misled by a deformity of the head, presently to be described.

On finding that there was a second child, the patient was given an injection of chloral and made comfortable in bed; she rested well until 5 o'clock next morning, when labor pains recurred very naturally for some three hours, after which they again slackened off as before. The membranes were ruptured and ergot administered, but the soft body of the fetus made no progress through the os, which was quite high up, as with the first child. The head presenting, it was determined to deliver with the crochet, which was done without difficulty. This, however, did not end our troubles, for while the uterus contracted fairly under ergot, the placenta failed to come away, though there was no sign of flooding, not even a stain of blood escaping from the os. Satisfied that only force could induce the after-birth to come away and that our patient was in no condition to apply it, we determined on a conservative policy. We prescribed

morphia with full doses of quinine and ergot, also meat juice or milk every two hours, and agreed to watch and wait. There being no sign of detachment of the placenta by the afternoon of that day, I came back to the city with the understanding that I would return next morning, by which time I hoped the detached mass would present itself at the external os. In this, however, I was disappointed, for I found not only that the afterbirth had not come down, but that there was not blood enough escaping to stain the finger when passed within the os. The patient was in a very unpromising condition, with a feeble, rapid pulse, and a temperature of 100°. It was decided to at once administer anæsthesia and proceed to detach and deliver the afterbirth. We had hoped, if this mass was really adherent (which the total absence of all bleeding indicated), that a delay of twenty-four hours would render its detachment much easier and safer, and there can be no doubt but that this was the case. For, while I searched in vain for any portion of the rim of the placenta which was not still closely clinging to the uterine wall, there was little effort required to effect detachment *en masse*, and so perfectly *intact* as to indicate conclusively that there was little or nothing left behind. The two placentæ in this case were fused into one, forming an exaggerated ellipse, which reached from side to side across the fundus uteri; an umbilical cord was attached near each extremity.

I am informed by Dr. Powell that our patient, after passing through an alarming stage of fever with abdominal tenderness and tympanites, is convalescing nicely.

One of the most interesting features in this case has yet to be related, and that was the physical condition of the second child. It was somewhat smaller than the first, was of the same sex, and apparently well formed with the exception of its head and right arm. The occipital bone was undeveloped, and the right forearm showed evidences of having been amputated between the middle and upper third. The limb was perfectly formed down to the stump, which latter presented a cicatrix in its centre, and was as well cushioned as any surgeon could make it. The two bony stumps could be distinctly felt,—their rounded tapering extremities being merged into the terminal cicatrix.

I regret that it was impossible to procure this specimen, for the reason that while exceedingly rare, instances of intra-uterine amputation have been sufficiently common to excite a widespread

professional interest and to elicit much discussion. The subject, however, is by no means exhausted, neither can it be said that the explanations which have been offered in accounting for these singular phenomena are such as will bear strict scrutiny in all cases. Unfortunately most that has been written on this subject antedates the present period of microscopical proficiency and close pathological and physiological research, and it is not improbable that a close examination of some of these cases might reveal a defective organization of certain nerve centers presiding over the nutrition of undeveloped parts. I am led to make this remark from the fact that it is difficult if not impossible to account satisfactorily for all of the deformities of this class on the commonly accepted theories of Montgomery, Simpson and others. It is well known that these writers ascribe such intra-uterine mutilations to purely physical instrumentalities, such as constrictions caused by the umbilical cord, or threads or organized lymph.

Now while it is pretty well established that such constricting agencies may thus operate, there are certain circumstances and considerations connected with a great many of these cases—as in the one I have just reported—which suggest a more profound and centric cause. If the mere wrapping of the cord around a limb is thus capable of producing amputation, why is it that the accident is so rare? Why is it that children are not more frequently decapitated, for we are all familiar with the fact that the cord is coiled once or twice around the neck of more than half the children we deliver? Why is it that the nutrition of the limb suffers, while the cord does not? Again, it is remarkable with what frequency we encounter these mutilations multiple in character,—involving sometimes all four extremities—or else associated with some palpable defect of development in other parts. Take the present case, for example; here we have not only amputation of the right arm, but also non-developement of the occipital bone. If this were an isolated instance, we might dismiss it as a mere accident without special significance. A very casual examination of recorded cases, however, will reveal a striking coincidence in this particular,—a point which seems to have escaped the notice of those who have contributed most to the early literature of this subject, but which is certainly worthy of thoughtful consideration.

Without pretending to go into a critical review of this sub-

ject, it will be easy to mention certain notable examples illustrative of the point I make. Dr. Montgomery, who has written extensively on the subject and who has contributed more to establish the physical theory of intra-uterine amputations than any other one man, mentions several cases where mutilation of the limbs was associated with marked defects in the organization of other parts. He reports one case very similar to my own, wherein certain bones of the head were wanting; also a second where there existed a large opening in the abdominal wall with an immense umbilical hernia. In the celebrated case of Zagorsky, the right foot was amputated, the left foot deformed, as was also both hands. In this same fœtus the parietal bones, the squamous portions of the temporal, the superior parts of the larger wings of the sphenoid and of the occipital bones, were wanting, as well as the common integuments of the calvarium. The face was also horribly malformed. Dr. Fitch reports a similar case in the *American Journal of Medical Sciences*, May, 1836, in which a foot was amputated; there was also a horny protuberance on the forehead, together with deficiency of portions of the upper lip and jaw bone. Indeed, it is not going too far to say that in the majority of these cases the amputation is associated with some other variety of mutilation or defect. This fact is alone significant, for it is a positive indication that there is something defective in the *autogenetic forces* of these children, whereby, it may be, that nutrition was cut off from certain parts during an early period of fœtal life.

Of course it will not do to deny that many of these are veritable amputations; that portions of the limbs have been separated from the body has been proven beyond doubt,—the severed member having in a few instances been discovered in the discharges, and in other instances clinging by a mere thread. I will say that nothing of the kind was discovered in the case I have reported, though it is possible that it may have been overlooked, which could easily occur, since in nearly all instances where the separated member has been found, it was exceedingly small. In some cases the foot or hand of the separated limb has been found better developed than the intermediate part connecting it with the point of severance, the latter apparently consisting of a small fibrous string. This circumstance suggests the idea of atrophy, of an acute shrinking away, disintegration and absorption of tissue. May it not be therefore that, in some in-

stances at least, intra-uterine amputations are effected by a process somewhat akin to acute muscular atrophy in the adult—a condition which many leading pathologists tell us is due to destruction of the trophic nerve cells? True, physiologists have not yet positively admitted the existence of nerves of nutrition, but, like the astronomer who divines the existence of a star which his telescope cannot reach, the pathologist has confidently asserted that such nerves and such centers must be among the recognized things of the near future.

I confess, Mr. President, that I have not had time to examine very thoroughly into the literature of this very interesting subject, but I am under the impression that very little has been accomplished in the way of studying the minute anatomy of such specimens. I cannot but believe, however, that when the subject is further investigated, new light will be thrown upon it, and that the true cause of many, if not most of these intra-uterine amputations, will be found to have a centric origin.

Playfair mentions one case (Reported by Mr. Scott, Obstet. Trans. Vol. XIII, page, 94) which goes far to show that all such amputations are not dependent upon mechanical causes; here there was an apparant hereditary tendency to such deformities. The grandfather had both forearms lacking, with rudimentary fingers attached; the next generation escaped; but the grandchild had a deformity precisely similar to the grandfather.

Ludwig has reported a dissection made of a fœtus born with its left arm amputated in the middle of the humerus. The blood-vessels, muscles and nerves of the mutilated member were found very much contracted as they approached its lower extremity and finally were changed into fibrous or cellular structure, near the surface of the stump. The humerus was natural at its upper parts, but below it became somewhat broader and flatter than natural, and terminated with two projections or tubera, representing on a diminutive scale the two condyles of this bone.

This latter case reminds us of another very singular phenomenon which has been observed in some of these cases, namely, the existence of minute tubera or projections on the ends of stumps, resembling rudimentary fingers or toes, actually tipped in some instances with nails. Dr. Simpson regarded these as instances of *bona fide* reproduction of lost parts, and argues very learnedly to show that the fœtus during the early stages of

intra-uterine existence possesses aptitudes known only in the lower scale of animal life. There is however one essential link in the chain of his argument which is lacking, and that is, that he has not proved that any of these cases were actual amputations. No instance has been recorded, so far as I know, where such rudimentary growths have been discovered as co-existing with the severed limb in the amniotic sac. Should the separated portion of limb be found and the stump at the same time present the appearance delineated by Prof. Simpson, there could be no longer any question as to the genuine reproduction of lost parts; but, until this is the case, there is abundant room for a good deal of skepticism. In other words, I am inclined, with some modifications, to accept the theory of Martin, who holds that the amputation in these instances is rather apparent than real, and that this singular deformity is due to arrest of development of the intermediate parts. Whether this non-development shall be proven to result from constricting bands, or be due to the absence of nutrition from some more centric cause, is a question which future pathologists and physiologists can alone decide.

CORRECTIONS.—In report of Dr. Porter's remarks on Chloroform, St. Louis Medical Society Proceedings in Journal, Aug. 20th, page 258, read: "Where death occurs from Chloroform, it is *often* the result of criminal carelessness.

The remarks of Drs. Porter and others. pp. 260-61 should have followed those of Dr. Lutz, pp. 255-56.—*Com. Pub.*

Clinical Reports from Private Practice.

REMOVAL OF A SCIRRHIUS GROWTH INVOLVING THE ENTIRE PAROTID GLAND. By JESSE E. THOMPSON, M. D., of Salem, Mo.

Mr. Bird, of Merimac township, Dent county, Mo.; æt. 50; first observed a tumor about the size of a hazel nut, in front of the right ear, during the year 1865. It gradually increased in size until 1873, when its dimensions resembled those of a goose egg. About this time I first saw the tumor, and recommended its removal by the knife. He subsequently fell into the hands of a "cancer doctor," who soon produced a very disagreeable and painful sore. In September, 1878, he applied to me for its removal. The pain had become unbearable, unless under the influence of morphine. His constitution had suffered considerably. I could not promise that it would not return, but that he might have a year or so respite from pain.

September 20th, assisted by Drs. Godbey, Love and Gray, of Salem, Mo., I operated. The patient was put under the influence of chloroform by Dr. Gray. The face was turned well to the sound side, while the chin was elevated. An incision was made beginning at the zygoma, extending to the lobe of the ear, then upward and behind the ear till the mastoid process was reached; thence along the inner border of the sterno-cleido-mastoid muscle downwards to the base of the ramus of the lower jaw. The flaps were dissected back till the parotid gland was exposed. Stenon's duct and the transverse facial artery were cut. The front portion of the tumor was detached as deep as the deeper part of the ramus of the jaw. In the same way the posterior part of the tumor was carefully separated from the anterior portion of the sterno-cleido-mastoid muscle, and the upper part down to the auditory process of the temporal bone; two or three small vessels were cut, and ligated. The dissection was now carried to the apex of the parotid gland, being done mainly with the handle of the scalpel. The external carotid was cut, but readily tied; pressure being made on the common carotid by

Dr. Godby, but little blood was lost. The wound was thoroughly examined and it was found that all the parotid gland had been removed, including every visible trace of the scirrhus growth. The wound was closed by sutures and a carbolized cotton compress placed over it and held by a bandage. On the next morning the whole right side of the face was cedematous; the right conjunctiva was very red; but by the third day these signs had all disappeared. The wound was washed with a ten grain solution of carbolic acid. In all respects the patient progressed well and was able to return to his home in four weeks. The pathological specimen was exhibited before the Rolla District Medical Society, at its November meeting, 1878, with a history of the case. The patient so far recovered his strength as to be able to sow fifteen acres of wheat in November following.

The wound healed perfectly, no traces of a return of the disease showed itself till the following spring, when it broke out in the interior of the mouth on the same side. He only survived two months.

News Items.

The St. Louis Medical Society meeting in the Public School Library building, southwest corner of 7th and Chestnut streets, commences its regular weekly sessions on Saturday the 18th of September. Dr. G. M. B. Maughs, President; Dr. Post, Recording Secretary.

Members of the medical profession are cordially invited to attend. There are valuable pathological specimens presented nearly every evening, and some times as many as three and four specimens are placed on the table.

The discussions are taken by the JOURNAL's and the Society's Stenographic Reporter, and published with the papers in the JOURNAL.

Book Reviews.

THE MICROSCOPIST: A Manual of Microscopy and Compendium of the Microscopic Sciences; Micro-Mineralogy, Micro-Chemistry, Biology, Histology, and Practical Medicine. 8vo. Fourth Edition, greatly enlarged, with 252 Ills. pp. 434. By J. H. WYTHE, A. M., M. D., Professor of Microscopy and Histology in Medical College of the Pacific, San Francisco, Cal. Philadelphia: Lindsay & Blakiston. [St. Louis: For sale by H. R. Hildreth Publishing Co., 407 N. Fourth St.]

This is a handbook which deals with its subject tersely and comprehensively and is just what students in microscopy need. To the advanced microscopist, it would not prove so valuable, although he could find hints and suggestions which only experience, such as has been the author's, could provide. The illustrations are all in tints and, on the whole, pretty fair. The outlines of each specialty, to which the microscope may be applied, are given with clearness and brevity, and when mastered, enable the investigator to trust to his own resources, to a great extent. Three new chapters, the most valuable to the practitioner of medicine, have been added to this edition, and one on the Microscope in Pathology, Diagnosis and Etiology. They are very comprehensive, useful and interesting. Besides this, an Appendix of recent additions to the microscope and microscopic technology, occupies some fifty pages, the genera of microscopic plants being embraced in this. A complete Glossary and Index completes over two hundred pages of new matter added to this edition. The book is a deserving one and will, doubtless, find its way to the book-shelves of many practitioners, and awake in them a greater zeal and the necessity of more time being devoted to the microscope.

THE BRAIN AS AN ORGAN OF THE MIND. By H. CHARLTON BASTIAN, M. A., M. D., F. R. S.; with 184 Illustrations; pp. 708. [New York: D. Appleton & Co., 1880.]

This volume is one which will be highly appreciated by the comparative physiologist. It is a treatise which is clear and comprehensive, and of a wide range. The author commences with a description of the uses and origin of a nervous system. He then further elaborates the subject by a chapter on its structure. He now commences to enter into an inquiry of the nervous systems of Mollusks, Vermes, Arthropods, Amphibia, Birds, Reptiles, etc., until he arrives to that of Man. These chapters are all well written and quite profusely illustrated with figures and diagrams, which greatly assist in rendering the subject clear. The human brain is viewed in all its aspects, anatomical, physiological and moral; and cerebral localizations, have a good share

of attention. Phrenology, old and new, receives a chapter for its consideration. The Appendix on the "Views Concerning the Existence and Nature of a Muscular Sense," contains the opinions of the most advanced thinkers on this question. On the whole, the book is very readable, and will repay a careful perusal.

TRANSACTIONS OF THE STATE MEDICAL SOCIETY OF ARKANSAS. at its Fifth Annual Session. 8vo.: pp. 120. [Little Rock: Printed by James Mitchell, State Printer.]

This little volume makes quite a showing for our friends in Arkansas. The Society is young yet, but promises a great deal for the future. Among the interesting papers in these transactions are: The Address, by E. T. Dale, Pres.; An Account of Yellow Fever, as it appeared in Forrest City, Ark., during the Summer of 1879, by J. B. Cummings; Expert Testimony without Compensation, by J. H. Southall; A Case of Fracture of Coronoid Process, by J. E. Bennett; Some Points in the Treatment of Pneumonia, by J. S. Shibley; and many other interesting papers which space forbids us to enumerate.

ATLAS OF SKIN DISEASES. By LOUIS A. DUHRING, M.D. Part VII, Eczema (Pustulosum), Impetigo Contagiosa, Syphiloderma (Papulosum), Lupus Vulgaris. [Philadelphia: J. B. Lippincott & Co., 1880.]

So much has already been said in praise of the excellent plates, that it seems a useless repetition to do so again. These plates are well executed, more particularly those of Syphiloderma and Lupus. As we have already remarked, no Dermatologist should be without those most valuable aids. The text is clear and concise, each plate being accompanied by a clinical history of the case there represented.

TRANSACTIONS OF THE SOUTHERN ILLINOIS MEDICAL ASSOCIATION, for the year 1880. Vol. II.; pp. 92. [St. Louis: Geo. O. Rumbold & Co.]

This little volume gives us the year's work of a Society whose influence is being largely felt by the profession in Southern Illinois. The papers though not numerous are very interesting, and are all marked with the evidences of thought. They are all of a practical nature, and are just what we can expect of men who are actively engaged in their practice. The Society, in issuing these transactions, evinces the spirit in which it labors, and shows us what it is doing. The names of the authors of all the papers attest to their general excellence, and these transactions are evidences of what the future will bring forth. One of the great advantages these transactions have enjoyed, is that they were published in the JOURNAL, thus being read by thousands, instead of being merely given to the hearers that attend the meetings.

Books and Pamphlets Received.

In Memoriam. Frank Howard Davis, M. D. [Reprint from the Chicago Medical Journal and Examiner, Sept. 1880.]

Report of the Indiana State Health Commission, Mortality Tables, etc., pp. 39. [Reprint from the Report of the Bureau of Statistics for 1879 : Indianapolis. 1880.]

Medical Science in Conflict with Materialism. By Eugene Grisson, M. D., L. L. D. Address delivered before the Medical Society of North Carolina, May 13th, 1880. [pp. 31, Wilmington, N. C. 1880.]

Anæsthesia by Ethyl Bromide. By H. Augustus Wilson, M. D. [Reprint from Medical and Surgical Reporter, Aug. 7th, 1880.]

Annual Announcement of the Medical Department of the University of Buffalo, for the Session 1880-81, with Catalogue of previous Sessions. [Buffalo, N. Y. 1880.]

Fifteenth Annual Announcement of the Medical Department of the Willamette University. Session of 1880-81. [Portland, Oregon. 1880.]

Report and Supplementary Report to the Parliamentary Bills Committee of the British Medical Association on Vaccination Penalties. By Ernest Hart. [Reprinted from the British Medical Journal of July 3d and 17th, 1880 : London. 1880.]

Transactions of the Medical and Chirurgical Faculty of the State of Maryland, at its Eighty-Second Annual Session, held at Baltimore, Md., April, 1880. 8 vo. pp. 216. [Baltimore. 1880.]

Practical Hints relating to Yellow Fever Prevention. By Robt. B. S. Hargis, M. D., of Pensacola, Fla. [Reprinted from the Independent Practitioner, July. 1880.]

On Occipital Headache as a symptom of Uremia. [Reprint from the Archives of Medicine, Aug. 1880.]

Optico-Ciliary Neurotomy, the proposed substitute for Extirpation of a Lost and Painful Eyeball. By Julian T. Chisolm, M. D. [Reprint from Transactions of the Medical and Chirurgical Faculty of Maryland. 1880.]

Sanitary Survey of Indianapolis. By Thad. M. Stevens, M. D., Secretary of the Indiana State Health Commission. Reprint from the Transactions of the Indiana State Medical Society. 1880.]

METEOROLOGICAL OBSERVATIONS.

By A. WISLIZENUS, M. D.

The following observations of daily temperature in St. Louis are made with a MAXIMUM and MINIMUM thermometer (of Green, N. Y.). The daily minimum occurs generally in night, the maximum at p. m. The monthly mean of the daily minima and maxima added and divided by two, gives quite a reliable mean of the monthly temperature.

THERMOMETER, FAHRENHEIT—AUG., 1880.

Day of Month.	Minimum.	Maximum.	Day of Month	Minimum.	Maximum.
1	73.0	88.5	18	78.0	98.0
2	74.0	80.0	19	81.0	99.5
3	59.0	75.0	20	74.0	87.5
4	58.0	79.0	21	68.5	82.0
5	61.0	83.0	22	66.5	92.0
6	65.5	87.0	23	73.5	91.0
7	68.5	88.5	24	76.0	94.0
8	69.5	90.0	25	75.5	93.5
9	76.0	81.0	26	76.5	93.0
10	70.5	86.0	27	75.0	91.5
11	71.0	89.0	28	73.5	88.5
12	68.5	86.0	29	72.5	90.0
13	67.5	88.0	30	72.0	
14	69.0	91.0	31	74.0	
15	72.0	93.0	Means.....	71.2	88.8
16	72.5	92.5	Monthly Mean.....	80	
17	76.0	95.0			

Quantity of rain, 1.0 inches.

MORTALITY REPORT.—CITY OF ST. LOUIS.

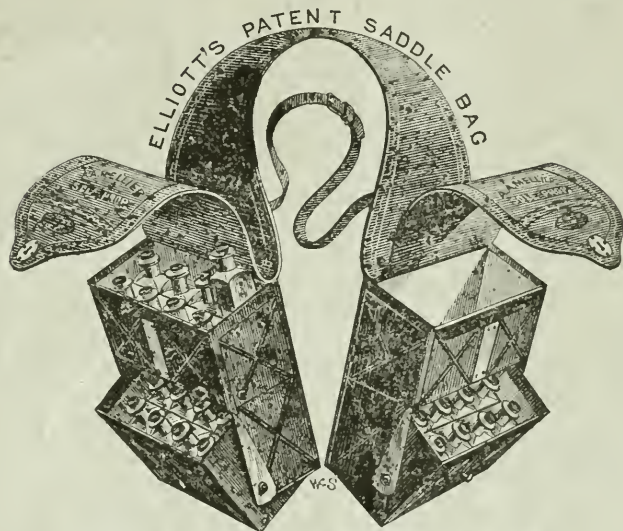
FROM JULY 31, 1880, TO AUG. 21, 1880, INCLUSIVE.

Effect of Solar heat	1	Child-birth	2	Convulsions & Trismus Neonatorum	38	Aneurism	1
Measles	0	Inanition, Want of Breast Milk, etc.	11	Hydrocephalus and Tub. Meningitis	10	Apoplexy	9
Syphilis	1	Alcoholism	5	Meningitis & Encephalitis	29	Parotitis	1
Scarlatina	3	Rheumatism & Gout	2	Other Diseases of the Brain and Nervous System	13	Aphthae	1
Pyæmia & Septicæ	1	Cancer and Malignant Tumor	9	Cirrhosis of Liver and Hepatitis	14	Premature Birth	0
Erysipelas	1	Phthisis & Tuberculosis, Pulmon.	52	Enteritis, Gastro-enteritis, Peritonitis, and Gastritis	15	Deaths by Suicide	4
Diphtheria	1	Bronchitis	7	Bright's Disease and Nephritis	3	Deaths by Accident	23
Membran's Croup	2	Senility	9	Other Diseases of Urinary Organs	2	Deaths by Homicide	6
Whooping Cough	10	Pneumonia	18	Diabetes	1	Congen Deformity	30
Ovarian tumor	1	Other Diseases of Respir'y Organs	14			Total Deaths from all Causes	579
Cholera Infantum	96	Metro-Peritonitis	1			Total Zymotic Diseases	203
Typhoid Fever	10	Marasmus—Tabes Mesenterica and Scrofula	42			Total Constitutional Diseases	115
Cerebro Spinal Fe.	1	Tonsillitis	1			Total Local Diseases	187
Remittent, Intermittent, Typho-Malarial, Congestive & Simple Contin'd Fevers	30					Total Develop'tal Diseases	41
Puerperal Fevers	2					Deaths by Violence	33
Diarrheal Disease	22						

CHAS. W. FRANCIS, Health Commissioner.

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Although comparatively a safe anæsthetic, we would still advise care in its use by those unfamiliar with its properties, and will be pleased to furnish circular containing report of case by Dr. J. Marion Sims, in which dangerous effects followed its use.

Jamaica Dogwood. (PISCIDIA ERYTHRINA.) The reports which have already been received of the effects of this drug more than justify our action in placing it before the profession of this country. Making due allowance for the enthusiasm which its action has aroused, we would only say, that whereas, we a short time since merely asked the profession to submit it to a trial, we are now justified in recommending it as a substitute for opium in many painful affections. Its advantages over opium lie in its not constipating or locking up the secretions, and in its leaving none of the unpleasant constitutional effects associated with the administration of opium.

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Gelatine Products. We would ask the especial attention of the medical profession and pharmacists to our line of gelatine and gelatine-coated preparations, comprising Empty Capsules, Improved Rectal Suppository Capsules, and Gelatine-coated Pills. Our facilities for the manufacture of these articles are unsurpassed, and the perfection to which we have brought them is due to the sparing of no expense in the securing of the best methods and the most experienced skill. We confidently ask a comparison of our Gelatine preparations with those of any other maker. We have but recently added Gelatine-coated pills to our stock, preferring to delay manufacturing them until we should be able to perfect a process through which the objections to gelatine-coated pills, as heretofore offered, might be entirely overcome. Our process is the result of years of experiment, and the expenditure of much capital. We claim for it complete freedom from the objections which attached to all the methods previously employed.

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